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MAKING MEDICAID WORK FOR THE MOST VULNERABLE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

FIRST SESSION

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MAKING MEDICAID WORK FOR THE MOST VULNERABLE

MONDAY, JULY 8, 2013

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 4:00 p.m., in room 2123, Rayburn House Office Building, Hon. Joseph R. Pitts (chairman of the subcommittee] presiding.

Present: Representatives Pitts, Burgess, Gingrey, Cassidy, Griffith, Bilirakis, Ellmers, Dingell, Barrow, Christensen, Castor, Sarbanes, and Waxman (ex officio).

Staff Present: Clay Alspach, Chief Counsel, Health; Matt Bravo, Professional Staff Member; Sydne Harwick, Legislative Clerk; Monica Popp, Professional Staff Member, Health; Andrew Pawaleny, Deputy Press Secretary; Noelle Clemente, Press Secretary; Alli Corr, Minority Policy Analyst; Amy Hall, Minority Senior Professional Staff Member; Elizabeth Letter, Minority Assistant Press Secretary; and Karen Nelson, Minority Deputy Committee Staff Director for Health.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. The time of 4:00 having arrived, we will call the subcommittee to order. The chair will recognize himself for an opening statement.

Today's hearing is the third in a series examining the current Medicaid system and ideas for reform. It builds on the subcommittee's March 18 hearing, "Saving Seniors and Our Most Vulnerable Citizens From an Entitlement Crisis," and our hearing of June 12, "The Need For Medicaid Reform: A State Perspective." It also complements the Energy and Commerce Committee's "Medicaid Check Up" report from March, Representative Upton and Senator Hatch's May report, "Making Medicaid Work," and the committee's recent Idea Lab on the program.

Medicaid was designed to protect the most vulnerable Americans, including pregnant women, dependent children, the blind, and the disabled. Nearly one in four Americans was enrolled in the Medicaid program at some point in 2012, making Medicaid the largest government healthcare program, surpassing Medicare. We have an obligation to ensure that the program provides quality health care

to beneficiaries and has the flexibility to innovate to better serve this population.

As we have seen, we are failing on both counts. Only 70 percent of physicians are accepting Medicaid patients, leading to problems with accessing care and scheduling follow-up visits after initially seeing a provider. Medicaid beneficiaries often lack access to primary care and preventive services and are twice as likely to visit the emergency room. In some cases, outcomes for Medicaid patients are worse than the outcomes of those who have no insurance at all.

Regarding flexibility, instead of encouraging States to pursue new and innovative models of care, we have locked them into a one-size-fits-all program dictated by Washington. When States do try to modernize and tailor their programs to the individual populations they serve, they often spend years waiting for the Centers for Medicare & Medicaid Services, CMS, to approve their waivers. Before we implement a Medicaid expansion which, if fully adopted, would add another 26 million Americans to the program, we must first address these issues in the current program.

I look forward to hearing from our witnesses today about ideas to strengthen this vital safety net, and I welcome all of them to our subcommittee.

And I yield the balance of my time to the gentleman from Louisiana, Dr. Cassidy.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

The Subcommittee will come to order.

The Chair will recognize himself for an opening statement.

Today's hearing is the third in a series examining the current Medicaid system and ideas for reform. It builds on the Subcommittee's March 18 hearing, ″Saving Seniors and Our Most Vulnerable Citizens from an Entitlement Crisis,″ and our hearing of June 12, ″The Need for Medicaid Reform: A State Perspective.″

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Before we implement a Medicaid expansion, which, if fully adopted, would add another 26 million Americans to the program, we must first address these issues in the current program.

I look forward to hearing from our witnesses about ideas to strengthen this vital safety net, and I welcome all of them to the Subcommittee.

Thank you.

Mr. CASSIDY. Thank you, Mr. Chairman.

The current debate over reforming the Medicaid program brings to mind—and I am paraphrasing Samuel Johnson—no one likes change, even from worse to better.

Even those who support Obamacare and Medicaid, the Medicaid component, said that they never would design Medicaid today as it was designed 50 years ago to meet today's needs. Now, there are many issues with the current Medicaid program. It serves a diverse group of people—children, adults in long-term care, the disabled, pregnant women, and now able-bodied adults. If the intent of Medicaid is to take care of the most vulnerable, I raise issue with the child or individual with traumatic brain injury having to compete for limited Medicaid funds with a healthy childless adult.

There is also great variability in how much Federal money each State receives per Medicaid beneficiary. As evidence, the five wealthiest States receive almost twice as much in Federal Medicaid contributions toward the care of their low-income residents than those living in the five poorest States. If the intent of Medicaid is an implicit Federal guarantee to provide a baseline of coverage for the most vulnerable, why should a disabled Medicaid recipient living in New York receive twice as much Federal Government aid as a disabled person living in California?

Other problems include quality and access to doctors. The chairman referenced a recent study that found that Medicaid patients have longer hospitalization, higher cost, and worse outcomes than even the uninsured. Yet despite being a high-cost program for States, Medicaid frequently pays below a physician's cost to see a patient, which effectively denies them access. Medicaid, as I like to say, is the illusion of coverage without the power of access.

I applaud the chairman and the committee for holding this hearing. We can't just simply add or subtract cash from the Medicaid system and call it reform. We have to be willing to reexamine the effectiveness of our Medicaid structure. I think that all the members of this committee can agree Medicaid should be structured in a way that provides benefits to individuals in the most efficient and effective way. I also would like to add that I recently introduced the Medicaid Accountability Care Act, which I hope can also be considered.

I yield the balance of the time to Dr. Gingrey.

Mr. GINGREY. Mr. Chairman—and I thank the gentleman for yielding—our Medicaid program has continually underperformed for our most needy population. Instead of focusing Medicaid dollars on new, healthier people, as in the President's health care law, we should be directing more attention to improving the health outcomes of the existing populations. We must allow the States the ability to experiment with their programs to approve our results. An outdated and overly bureaucratic waiver process does not allow the proper freedom to develop new methods to deliver care to our poorest and most vulnerable.

Mr. Chairman, it is past time to repeal the maintenance of effort provisions in Obamacare and release the States to investigate novel ways to improve on a system that currently fails its participants. And thank you for the extra time, and I yield back.

Mr. PITTS. The chair thanks the gentleman.

Recognize the gentleman from Maryland, Mr. Sarbanes, who is filling in for the ranking member today.

OPENING STATEMENT OF HON. JOHN P. SARBANES, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Mr. SARBANES. Thank you, Mr. Chairman. I appreciate your convening this hearing on the very important subject of the Medicaid program.

As you, yourself, said, Medicaid is an important program. We view it as a critical safety net that provides healthcare coverage for those individuals who have been shut out of private insurance, either because that is unaffordable to them or it is unavailable or it doesn't cover the benefits that they need.

It is important to recognize that when we talk about the Medicaid program, we are not just talking about a program that covers low-income families. We are talking about a program that covers children and adults with disabilities, and pays for nearly half of all long-term care services.

I had the privilege for 18 years of representing a number of health care providers as an attorney, in particular those who provide services to our elderly, and I understand how critical the support from the Medicaid program is for a lot of the services that are provided to those most in need among our elderly. And so it is important for us to understand the full dimensions of the Medicaid program. We are talking about home- and community-based services, we are talking about rehabilitative therapy, and we are talking about adult daycare and caregiver respite.

In 2011—and you mentioned this yourself—the Medicaid program provided healthcare assistance for almost one out of every four or five people in the country, including 30 million children. That is why it is so critical to make sure that this program remains strong and that we build upon the most important elements of it.

I am particularly focused on how we can bring this kind of coverage to bear where people are. It is what I call place-based health care. I have championed efforts, particularly with respect to young people, to make sure that those who are eligible for Medicaid can get that care wherever they may be and where it is easiest for their families to receive it, including in their schools and in school-based health clinics.

The coverage for children under Medicaid is really one of the most important aspects of the program. And I would like to enter into the record, without objection, testimony from the American Academy of Pediatrics on this issue of why it is so important both to pediatricians and obviously to children as well. This is from Robert Hall with the American Academy.

Mr. PITTS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. SARBANES. The Affordable Care Act, as we know, includes an expansion of the Medicaid program to include more low-income adults, taking it up to 138 percent of the poverty rate. Half of today's uninsured have incomes below the new Medicaid limit. So they stand to benefit from this adjustment going forward. Unfortunately, we do have States across the country who so far have de-

clined to become partners in this effort, take advantage of the Medicaid expansion. The result of that is that you will have many low-income adults who will likely remain uninsured, with predictable results both for them and for our society.

We also have to look at this through an economic lens. And as the economy continues to improve, more and more people are still finding themselves in need of this very important healthcare safety net. If you cut Medicaid, that is essentially cutting jobs. Medicaid stimulates the economy. Every dollar spent is good economics. According to one study by the Kaiser Family Foundation, every dollar cut from Medicaid means up to $2.76 cut from the State economy in which that occurs. The loss of Federal Medicaid dollars means a loss of healthcare jobs and healthcare economic activity across the country, which means you are moving States in exactly the wrong direction that we want to be pushing them in terms of our economic recovery.

States and the Federal Government need to focus on creating jobs, on incentivizing economic growth, not on cutting the most vulnerable programs, such as Medicaid. So I believe the expansion of the Medicaid program under the Affordable Care Act is not only something that makes tremendous sense for the health of vulnerable populations across the country, but for State economies as well. And I look forward to hearing from our witnesses today as they discuss this critical program and how we can all continue to push for quality affordable health care for all our citizens.

With that, I yield back.

Mr. PITTS. The chair thanks the gentleman.

And now yields to the vice chair of the subcommittee, Dr. Burgess, for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. I thank the chairman for yielding.

As we meet here today to discuss Medicaid, recognize that it was created to protect and care for some of the poorest and most needy in our Nation. However, in reality, the program, because of weak oversight, chronic underpayment of providers, lack of coordination of benefits, ends up being only another empty promise made by the Federal Government. The ability of Medicaid to provide healthcare coverage for the most vulnerable is further threatened by the Affordable Care Act and the drastic expansion of the program to nearly 72 million Americans in 2014.

Medicaid currently consumes almost a quarter of States' budgets, surpassing expenditures on education, transportation, and emergency services. Many States have been forced to cut Medicaid reimbursement rates to providers as a way to address budget shortfalls.

Look, as someone who has provided services to Medicaid beneficiaries, I understand firsthand that coverage does not guarantee access. Medicaid low reimbursement actually creates increased barriers to care, limiting beneficiaries' access to services because Medicaid pays less for comparable service than private insurers or, in some instances, even Medicare itself, making finding providers and appointments hard and sometimes impossible. Escalating costs and

shrinking access are symptoms of the greater systemic problems within the Medicaid system.

And look, we need to move beyond small reforms and instead address the underlying system's structural problems. We sat here this very room with a Health Subcommittee hearing in 2008 and talked about this very problem. Many of you will remember, it was the day that Lehman Brothers collapsed and the economy was headed for a crisis. We heard in that hearing that day that if you wanted to do health care reform on the cheap you just expand Medicaid. You are not really paying the providers to see the patients but, after all, that is not really what is critical, it is critical that we provide the coverage.

Well, anyone who has practiced in the Medicaid system will tell you that the ability to meet the cost of providing the care is critical for a hospital, for a clinic, for a doctor's office. And if you can't meet that, your doors will quickly be closed. But as we sat here in that room that day in September, we never even asked ourselves, is the best we can do Medicaid? And wouldn't we be better to reform the program before we expanded it? But unfortunately, those questions were never answered.

So I would submit today, it is time for us to get back to the basics. We need to ask ourselves, what was Medicaid created to do, and is it doing the best it can do under the circumstances? We know the structural and fiscal problems in the healthcare system. How long will America tolerate staring at these problems without fixing them for future generations?

It is time not just to reform Medicaid. We actually need to reboot the entire system. As we have seen from the events of the last week and a half, the problems in the Affordable Care Act are beginning to mount. They are reaching critical mass. This subcommittee has within its power to take up this issue and act.

I thank the chairman. And I will yield the balance of my time to the full committee chair, who is not here, so I will yield back my time.

Mr. PITTS. The chair thanks the gentleman.

Now recognize the ranking member of the full committee, Mr. Waxman, 5 minutes for an opening statement.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you very much Mr. Chairman.

The hearing today is called "Making Medicaid Work For the Most Vulnerable." I think that is a good topic. But I do want to talk about what the Republicans have proposed. They have proposed making Medicaid a block grant. So the States would be told, this is the amount of money you would get, no more, no less, you don't have to do anything, no requirements, do the best you can. And if you can't afford to do what you have been doing, well, you do less. That is up to you.

What the Republicans, in effect, are proposing is to shift the responsibilities to the States, the cost to the patients and providers, and avoid continuing a Federal responsibility. Block grants, or per capita grants, increases in beneficiary premiums and copays do not

reduce healthcare costs, but simply shift the cost onto the beneficiaries, providers, and States. And they make it less likely that people will be able to access care when they need it.

Are there things we can do to improve the program? Certainly. One thing we could do is to make it a Federal program, not have State differences, have a Federal Medicaid program, guarantee that providers will get the same reimbursement rates as the Medicare providers get paid. That would improve the program. But I don't think that is something that we are likely to hear much support for from the majority party that is in control.

I think this is a good hearing to have. I know we have a number of witnesses. I am particularly interested in hearing from Mr. Weil on what the States have been able to do to make the program innovative, effective, and efficient, cover low-income beneficiaries within the flexibility afforded the State Medicaid programs right now. Things the States can do today. I believe Mr. Weil will tell us that States continue to advance their Medicaid programs by implementing innovations, such as the multipayer collaboratives to improve access to primary, well-coordinated care; efforts to increase access to higher-quality, lower-cost developmental and oral health services; and others for the prevention of chronic disease.

Due to efforts like these, multiple studies have shown that Medicaid enrollees have comparable access to care as those with private coverage and much more reliable access than to those who are uninsured. When we hear complaints about Medicaid, the Republicans are forgetting that before Medicaid these people were uninsured and didn't have access to any care. And under the Medicaid program, if beneficiaries can get access with lower cost sharing, if we make very poor people—which is the bulk of who the Medicaid patients are—have to come up with more money out of pocket, they just won't have access to care because they can't afford it. Not only does the Medicaid program ensure equal access to care, it operates with efficiency. Medicaid costs are nearly four times lower than average private plans.

And there are other proposals that I think will streamline State payment systems, improve provider reimbursement timelines, ultimately increase their participation in State programs. One thing that I am very proud of is that at least we are going to, for a couple of years, require that preventive and primary care providers be paid the same rate as Medicare. But we didn't make that a permanent change, which would make a lot of sense. We put it in for a couple of years only in hopes that after it is in, people will—either at the Federal level or the State level—will try to keep it in place because it makes a lot of sense. If we can't afford to pay everybody a Medicare rate who serves Medicaid patients, at least pay those for whom we would like people to have access the most, and those are people who will provide primary and preventive care.

The Affordable Care Act expands the Medicaid program. I think this is a good thing to do. And I am proud of the Affordable Care Act. I think it is going to mean for millions of people they are going to have access to care, access to health insurance, whether it is through Medicaid, if they are lower income, or through the purchase of a private health insurance plan in the marketplace exchanges.

Let's stop complaining, let's make this law work because the Republicans don't have anything to offer but driving costs and shifting them over to people who can't afford to pay them and thereby denying them the services they need.

Thank you, Mr. Chairman. Yield back my time.

Mr. PITTS. Chair thanks the gentleman.

That completes the opening statements of the members. We have one panel today. I will ask them to take their seats at the table. And I will introduce them at this time.

First we have Ms. Nina Owcharenko, director, Center for Health Policy Studies of the Heritage Foundation. Secondly we have Mr. Alan Weil, executive director of the National Academy for State Health Policy. And finally, Mr. Tarren Bragdon, president and CEO, Foundation for Government Accountability.

Welcome. Thank you for coming today. You will each have 5 minutes to summarize your testimony. Your written testimony will be entered into the record. And so at this time, Ms. Owcharenko, we will recognize you for 5 minutes for your opening statement.

STATEMENTS OF NINA OWCHARENKO, DIRECTOR, CENTER FOR HEALTH POLICY STUDIES, HERITAGE FOUNDATION; TARREN BRAGDON, PRESIDENT & CHIEF EXECUTIVE OFFICER, FOUNDATION FOR GOVERNMENT ACCOUNTABILITY; AND ALAN WEIL, EXECUTIVE DIRECTOR, NATIONAL ACADEMY FOR STATE HEALTH POLICY

STATEMENT OF NINA OWCHARENKO

Ms. OWCHARENKO. Chairman Pitts, Ranking Member Waxman, and members of the committee, thank you for having me today.

As has already been well noted, the challenges facing the Medicaid program are not new. These challenges are unavoidable and raise serious concerns about whether Medicaid will be able to meet the needs of those who are enrolled in the program today, especially the most vulnerable.

The program serves a very diverse group of low-income people: children, pregnant women, disabled, and the elderly. The Affordable Care Act adds to this growing government health program by expanding eligibility to all individuals with incomes below 138 percent of the poverty level. And unlike traditional Medicaid, eligibility will be based on income alone.

I see three major challenges facing Medicaid in the future: demographic, structural, and fiscal.

The demographic challenges. With in the addition of the new Medicaid expansion, the Centers for Medicare & Medicaid Services' 2011 Actuarial Report on Medicaid projects that nearly 80 million people—one in four—will be on Medicaid by 2021. By enrollment alone, children will remain the largest and primary category of Medicaid enrollees, although it is worth noting that as a result of the Affordable Care Act, the able-bodied, non-elderly adults will be a very close second. But while only 16 percent of total enrollment, 64 percent of spending in 2011 was for the aged and disabled. As these competing trends continue, Medicaid will be more diverse and more complex to administer.

Structural challenges. Payment rates are one of the key indicators for access and physician participation in Medicaid, it has already been noted today. In its annual report to Congress, MACPAC notes that while varying by State, Medicaid fee-for-service payments to physicians are on average two-thirds those of Medicare and even worse for primary care services. A 2006 published survey found that 21 percent of physicians reported that they were not accepting new Medicaid patients while only 4 reported not taking new privately insured patients and 3 percent reported not taking new Medicare patients.

While the Affordable Care Act did provide Federal funding to boost Medicaid payments for primary care physicians, that funding, as has been noted, is temporary. And also as noted by the MACPAC report, several States have already indicated that it is unlikely that they will be able to maintain those new rates. Therefore, access and quality issues will remain a challenge for Medicaid beneficiaries in the future.

Fiscal challenges. Entitlements, including Social Security, Medicare, and Medicaid, are fueling this country's spending crisis. These three programs represent 62 percent of the Federal budget in 2012 and will absorb all tax revenue by 2048. By 2021, total Federal and State spending on Medicaid alone is projected to reach $795 billion and 3.2 percent of GDP by 2021.

For States, which have to operate under a real budget, the fiscal situation is no better. When the Federal contributions are included, Medicaid is the largest budget item for State budgets, representing 24 percent. In its recent fiscal report, the GAO warned that absent any intervention or policy changes, State and local governments would face an increasing gap between receipts and expenditures in the coming years. This is due in large part to rising healthcare costs for Medicaid, as well as health benefits for government employees and retirees.

Although these fiscal challenges are well established, the lack of action only makes the future outlook worse for Medicaid and its beneficiaries. I suggest there are a few basic principles that should guide efforts to addressing the key challenges facing Medicaid.

One, meet current obligations. Rather than expanding to new populations, attention should be given to ensuring that Medicaid is meeting the needs of existing Medicaid beneficiaries. Moreover, population should be prioritized based on need first.

Two, return Medicaid to a true safety net. Medicaid should not be the first option of coverage but a safety net for those who cannot not obtain coverage on their own. Careful attention should be given to transitioning those who can into the private insurance market.

Three, integrate patient-centered, market-based reforms. Efforts to shift from traditional fee for service to managed care have accelerated at the State level, but more should be done. Empowering patients with more choices and spurring competition among providers, including insurers, will help to deliver better quality of care at a lower cost.

Four, ensure financial sustainability. Similar to other entitlement reforms, the open-ended Federal financing model of Medicaid means reform. Sound budgeting at the Federal and State levels

should provide a predictable and sustainable path for the program and taxpayers alike.

In conclusion, I think it is encouraging to see efforts both in the House and in the Senate that are aimed at addressing these serious challenges facing Medicaid's future. With Federal and State policymakers working together, meaningful change in Medicaid will ensure that the most vulnerable are not left behind.

Thank you.

Mr. PITTS. The chair thanks the gentlelady.

[The prepared statement of Ms. Owcharenko follows:]

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CONGRESSIONAL TESTIMONY

Making Medicaid Work for the Most Vulnerable

Testimony before
Committee on Energy and Commerce
Subcommittee on Health
United States House of Representatives

July 8, 2013

Nina Owcharenko
Director, Center for Health Policy Studies
The Heritage Foundation

My name is Nina Owcharenko. I am the Director for the Center for Health Policy Studies at The Heritage Foundation. The views I express in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation.

Making Medicaid Work for the Most Vulnerable

The challenges facing the Medicaid program are not new. These challenges—demographic, structural, and fiscal—are unavoidable and raise serious concerns about whether Medicaid will be unable to meet the needs of those who are enrolled in the program, especially the most vulnerable.

The program serves a very diverse group of low-income people: children, pregnant women, disabled, and elderly. In some states, Medicaid has expanded beyond these traditional groups to include others, such as parents and, in a few cases, even childless adults. The traditional program and incremental changes have resulted in Medicaid serving on average over 57 million people (and over 70 million at some point) in 2012 at a combined federal–state cost that was expected to reach over $430 billion.

The Affordable Care Act (ACA) did not address the long-term challenges facing the Medicaid program. The ACA adds to this growing government health program by expanding eligibility to all individuals with incomes below 138 percent of the Federal Poverty Level (FPL). This is a significant change. Unlike traditional Medicaid, with income *and* categorical eligibility requirements such as disability, eligibility for the expansion population is based solely on income.

Medicaid at Risk

- **Demographic Challenges.** With the addition of the new Medicaid expansion, the Centers for Medicare and Medicaid Services' *2011 Actuarial Report on the Financial Outlook for Medicaid* projects that nearly 80 million people (one in four) will be on Medicaid by 2021.[1] Of this increase, the *Actuarial Report* projects that just over 30 million enrollees will be children, followed by 28.5 million adults, 10.2 million disabled, and 6.5 million aged. By enrollment alone, children remain the largest and primary category of Medicaid enrollees, although

[1] Centers for Medicare and Medicaid Services, *2011 Actuarial Report on the Financial Outlook for Medicaid*, March 16, 2012, p. 22, http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2011.pdf. It is also worth noting that this estimate is based on the assumption that not all states will choose to accept the ACA Medicaid expansion. The Actuaries estimate that if all states expanded, the number of enrollees by 2021 would reach 85 million and that, even without expansion, enrollment would reach close to 60 million due to the ACA's other interactive effects. See ibid., pp. 40, 41.

it is worth noting that as a result of the ACA expansion, able-bodied, non-elderly adults are now a very close second.

In 2011, the aged and disabled accounted for over 64 percent of spending but only 16 percent of total enrollment. Setting aside enrollment growth due to the new expansion, the *Actuarial Report* points out that "growth in aged adults is expected to be faster than the other categories of enrollment."[2] The report also notes that "Per enrollee costs for the disabled have been increasing at a faster pace than for aged beneficiaries."[3]

The further expansion of the Medicaid program alongside the aging populations makes Medicaid more diverse and more complex.

- **Structural Challenges.** In its annual report to Congress, the Medicaid and CHIP Payment and Access Commission (MACPAC) notes that while varying by state, Medicaid Fee for Service (FFS) payments to physicians are, on average, two-thirds those of Medicare and even worse for primary care services.[4]

  Payment rates are a key indicator for physician participation in Medicaid. A 2006 published survey found that 21 percent of physicians reported that they were not accepting new Medicaid patients, while only 4 percent reported not taking new privately insured patients and 3 percent reported not taking new Medicare patients.[5] A survey of the peer-reviewed academic literature illustrates that access and quality are problems for children as well as for adults in Medicaid.[6]

  While the ACA did provide federal funding to boost Medicaid payments for primary care physicians, that federal funding is temporary, which means that states will either return to previously set levels or face new costs. As noted in the MACPAC report, several states have indicated that it is "unlikely" they will be able to maintain the new rates.[7]

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[2] *Ibid.*, p. 30.
[3] *Ibid.*, p. 27.
[4] Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP*, June 2013, p. 50, http://www.macpac.gov/reports.
[5] Peter Cunningham and Jessica May, "Medicaid Patients Increasingly Concentrated Among Physicians," Center for Studying Health System Change, *Tracking Report* No. 16, August 2006, http://www.hschange.com/CONTENT/866/866.pdf.
[6] Kevin D. Dayaratna, "Studies Show Medicaid Patients Have Worse Access and Outcomes than the Privately Insured," Heritage Foundation *Backgrounder* No. 2740, November 7, 2012, http://www.heritage.org/research/reports/2012/11/studies-show-medicaid-patients-have-worse-access-and-outcomes-than-the-privately-insured.
[7] MACPAC, *Report to the Congress on Medicaid and CHIP*, p. 55.

Therefore, access and quality issues will remain a challenge for Medicaid beneficiaries in the future.

- **Fiscal Challenges.** Entitlements, including Social Security, Medicare, *and* Medicaid, are fueling the country's spending crisis. These three programs represented 62 percent of the federal budget in 2012 and will absorb all tax revenue by 2048.[8] By 2021, total federal and state spending on Medicaid alone is projected to reach $795 billion ($478 billion in federal spending and $314 billion in state spending) and 3.2 percent of GDP by 2021.[9]

  For states, which have to operate under a real budget, the fiscal situation is no better. In its recent *State and Local Government' Fiscal Outlook* report, the Government Accountability Office warned that "absent any intervention or policy changes, state and local governments would face an increasing gap between receipts and expenditures in the coming years" due in large part to the rising health-related costs of Medicaid and health care benefits for government employee and retirees.[10] When the federal contributions are included, Medicaid is the largest budget item for state budgets, representing 24 percent.

  Although these fiscal challenges are well-established, the lack of action only makes the future outlook worse for Medicaid and its beneficiaries.

Guiding Principles

Four fundamental principles should guide efforts to address the key challenges facing Medicaid.

- **Meet current obligations.** Rather than expanding to new populations, attention should be given to ensuring that Medicaid is meeting the needs of existing Medicaid beneficiaries. Moreover, populations should be prioritized based on need.

- **Return Medicaid to a true safety net.** Medicaid should not be the first option for coverage but a safety net for those who cannot obtain coverage on their own. For those who can afford their own coverage, careful attention should be given to transitioning them into the private market.

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[8] Alison Acosta Fraser, ed., "Federal Spending by the Numbers 2012," Heritage Foundation *Special Report* No. 121, October 16, 2012, http://www.heritage.org/research/reports/2012/10/federal-spending-by-the-numbers-2012.

[9] Centers for Medicare and Medicaid Services, *2011 Actuarial Report on the Financial Outlook for Medicaid*, p. 50.

[10] U.S Government Accountability Office, *State and Local Governments' Fiscal Outlook: April 2013 Update*, GAO-13-546SP, April 30, 2013, http://www.gao.gov/assets/660/654255.pdf.

- **Integrate patient-centered, market-based reforms.** Efforts to shift from traditional fee for service to managed care have accelerated, but more should be done. Empowering patients with choice and spurring competition will help to deliver better quality at lower cost.

- **Ensure fiscal sustainability.** Similar to other entitlement reform efforts, the open-ended federal financing model in Medicaid needs reform. Budgeting at the federal and state levels will provide a predictable and sustainable path.

Conclusion

It is encouraging to see efforts in the House and Senate that are aimed at addressing the serious challenges facing Medicaid's future. With federal and state policymakers working together, meaningful change in Medicaid will ensure that the most vulnerable are not left behind.

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Mr. PITTS. Now recognizes Mr. Weil for 5 minutes for an opening statement.

STATEMENT OF ALAN WEIL

Mr. WEIL. Thank you, Mr. Chairman, members of the committee. I appreciate the opportunity to appear before you today.

I am the executive director of the National Academy for State Health Policy, a nonprofit, nonpartisan organization that works with State leaders to promote excellence in State health policy and practice. My own experience includes a cabinet position in Colorado running the Medicaid agency.

Ten years ago I wrote that Medicaid is the workhorse of the American health care system, and that characterization remains true today. Unambiguous evidence demonstrates Medicaid's success in providing access to care and relieving the financial burdens associated with that care.

My testimony is a report from the field where I observe a Medicaid program that is dynamic, continually evolving to meet the changing needs of vulnerable populations, leading how care is structured and delivered, and participating in transformations of care delivery that are occurring around the country.

For example, Medicaid has led the way in promoting the use of developmental screening methods to identify children who would benefit from early intervention services. The percentage of children receiving such screening has grown from under 20 to more than 30 percent. In North Carolina, it is 75 percent. Nationwide, children with public health insurance are actually more likely to receive critical developmental screenings than children with private health insurance.

In 2000, Surgeon General David Satcher called poor oral health America's silent epidemic. Medicaid programs around the country are actively pursuing efforts to ameliorate this crisis through early interventions in medical practices, not just in dental offices. Washington State and Maryland, among others, have innovative programs designed to increase access to dental care for vulnerable children.

Medicaid is the Nation's primary payment source for long-term services and supports, and now States are spending more than a third of their long-term service budgets on home- and community-based supports that meet people's needs more effectively and more humanely.

In the area of eligibility and enrollment, Louisiana has led the way in streamlining processes for Medicaid applicants and those seeking to renew their coverage. Oklahoma launched the Nation's first online realtime enrollment system for Medicaid.

But some of the most exciting work in Medicaid is how it works with other private and public programs. All but three States now rely on managed care for delivering care to at least some of their Medicaid enrollees. Two-thirds of Medicaid enrollees receive most or all of their benefits in managed care. And States are increasingly relying on mandatory managed care programs in Medicare for more complex populations, such as children with special healthcare needs and people of all ages with a variety of disabilities.

Medicaid has been a leader in promoting the development of patient-centered medical homes; 29 States have launched one or more programs in Medicaid or the Children's Health Insurance Program to promote patient-centered medical homes. In 18 of those States, public and private payers and purchasers are working together to support these medical home projects. And in 15 of those initiatives, Medicare is also a participant.

The health home model is an extension of the medical home that integrates physical health, behavioral health, long-term services and supports to meet the needs of the most complex populations. A dozen States are pursuing these integrated models with support from the Federal Government under the Affordable Care Act.

Back in 2006, when Massachusetts reformed its healthcare system, it took a blended personal health and public health approach to smoking cessation services for Medicaid enrollees. In Massachusetts, smoking prevalence among Medicaid enrollees dropped by 26 percent in just 2 years, with significant health cost savings as an added benefit.

Around the country, Medicaid programs are pursuing new models of accountable care that encourage health care providers to organize and coordinate care as they accept financial risk and accountability for health outcomes. The structure of these programs is as varied as the States that are pursuing them: New Jersey, Minnesota, Illinois, Colorado, Oregon. The States are taking approaches that meet their own needs. Twenty-five States have received support to test or further develop comprehensive multipayer payment and delivery system reforms through funding from the Centers for Medicare & Medicaid Innovation State Innovation Model cooperative agreements. These States are pursuing the shared aim of better care and improved population health at a lower cost, using their Medicaid programs as a catalyst for system improvements that embrace not just Medicaid, but Medicare and private payers and private providers as well.

Medicaid is surely a complex program, but it is also a very dynamic program. It is also surely open to improvement, as is anything that we have created. But fundamentally, as I look out at the experience of the States and what is going on out in the field, I see a program that works for America's most vulnerable.

Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman.

[The prepared statement of Mr. Weil follows:]

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TESTIMONY BY ALAN R. WEIL

Executive Director
National Academy for State Health Policy (NASHP)

Before the
Energy and Commerce Committee
Subcommittee on Health
United States House of Representatives

Hearing on
Making Medicaid Work for the Most Vulnerable

July 8, 2013

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EXECUTIVE SUMMARY

Medicaid is the "workhorse" of the American health care system. It is not glamorous, but it is effective in achieving its goals of providing access to health care services and relieving the financial burden associated with care for those least able to afford it. Medicaid is a dynamic program that is evolving to meet the changing needs of vulnerable populations, leading change in how care is structured and delivered, and participating in the nationwide transformation of care delivery and financing.

In this testimony I describe steps Medicaid is taking to address the particular needs of the population it serves. Examples of the kind of innovation that occurs continually within the Medicaid program can be found in the areas of developmental screening, oral health, long term services and supports, and eligibility streamlining.

I then discuss how Medicaid is working with other public and private systems to promote better health outcomes and a more efficient, better organized health care system. I review six examples of these interdisciplinary approaches: Medicaid managed care, patient-centered medical homes, health homes, integration with public health, accountable care models, and the State Innovation Models program.

I conclude by noting that Americans who are without health insurance seek access to care and to be treated with dignity, just like anyone else. While the nation debates the future of Medicaid and the future of the health care system, Medicaid is the only practical option millions of vulnerable Americans have for meeting their health care needs.

Chairman Pitts, Ranking Member Pallone, and members of the committee, I appreciate the opportunity to appear before you today to discuss how Medicaid is meeting the needs of the most vulnerable Americans. I am the Executive Director of the National Academy for State Health Policy (NASHP), a non-profit, non-partisan organization dedicated to excellence in state health policy and practice. NASHP works with state leaders to identify emerging issues, develop policy solutions, and support innovation in policy and practice. Prior to joining NASHP, I directed a major research project at the Urban Institute, and, before that, I was executive director of the Colorado Department of Health Care Policy and Financing, which is the state Medicaid agency.

Medicaid Overview

Ten years ago, I called Medicaid the 'workhorse' of the American health care system.[1] That characterization remains true today. Medicaid is not glamorous, but it is strong and effective in achieving its goals. Medicaid provides access to critical health and social supports for the most vulnerable Americans, whether they are poor children and their families; people with profound health care needs such as those with traumatic brain injuries, serious and persistent mental illnesses, cerebral palsy, multiple sclerosis, Down's syndrome or autism; or in need of social supports due to frailty or dementia. Medicaid is an expression of our nation's commitment to the most vulnerable.

Because the Medicaid program is so complex, it is worth reminding ourselves of a few important facts. In 2012, Medicaid covered more than sixty-two million Americans.[2]

[1] Weil, A. There's Something About Medicaid. Health Aff (Millwood). Jan 2003 22(1):13-30.
[2] Kaiser Family Foundation. Medicaid: A Primer-Key Information on the Nation's Health Coverage Program for Low-Income People. Washington (DC): KFF. 1 Mar 2013. Accessible from: http://kff.org/medicaid/issue-brief/medicaid-a-primer/

Children and their parents account for about forty-seven million of these, but despite representing seventy-five percent of enrollment, they only account for thirty-four percent of spending. Fully forty-two percent of Medicaid program costs are associated with meeting the needs of people with disabilities, while the remaining twenty-three percent are spent on elders, where Medicaid fills in the significant gaps in Medicare coverage—most critically Medicare's lack of a long-term care benefit.[3] Medicaid is administered by the states within federal standards, and is financed jointly by the two levels of government. In FY 2011, federal Medicaid expenditures were $275 billion, where they represented 7.6% of the federal budget, while state Medicaid expenditures were $157 billion, representing on average 23.7% of state general fund spending.[4,5]

Just like private health insurance, Medicaid is a financing mechanism. Its primary functions are to provide access to health care services and relieve the financial burden associated with care for those least able to afford it. Evidence demonstrating Medicaid's success in achieving these goals is unambiguous. Myriad studies compiled in the Institute of Medicine's 2009 report "America's Uninsured Crisis" conclude that Medicaid and the Children's Health Insurance Program improve access to services, increase the likelihood that an enrollee will have a usual source of care, increase the use of primary and preventive services, and reduce unmet medical needs.[6] One recent study from

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[3] Kaiser Family Foundation. Medicaid Enrollees and Expenditures, FFY 2009. KCMU/Urban Institute estimates based on data from FFY 2009 MSIS and CMS-64, 2012. Washington (DC): KFF. Accessible from: http://kff.org/medicaid/slide/medicaid-enrollees-and-expenditures-ffy-2009/

[4] Congressional Budget Office. Federal Grants to State and Local Governments. Washington (DC): CBO. 5 Mar 2013.Accessible from: http://www.cbo.gov/sites/default/files/cbofiles/attachments/43967_FederalGrants.pdf

[5] National Association of State Budget Officers. State expenditure report: examining fiscal 2010–2012 state spending. Washington (DC): NASBO; 2012. Available from: http://www.nasbo.org/sites/default/files/State Expenditure Report_1.pdf

[6] Institute of Medicine of the National Academies: Committee on Health Insurance Status and Its Consequences, Board on Health Care Services. America's Uninsured Crisis: Consequences for Health and

Wisconsin shows enrollment in Medicaid leading to reductions in hospitalizations and, in particular, preventable hospitalizations.[7]

People without health insurance live sicker and die younger than those with any form of health insurance, including Medicaid.[8] When Medicaid coverage expands, deaths decline.[9] For statistical and ethical reasons, it is hard to tie a specific form of health insurance to specific improvements in health, but recent research provides important evidence of some direct health benefits associated with Medicaid coverage even as it fails to show evidence of improvement in other areas. I am unaware of any private health insurance plan that has been subject to the same scrutiny as Medicaid regarding its health effects, yet the vast majority of Americans would never question if having health insurance is good for them.

At a time when Medicaid is poised for growth and the country is debating the program's efficacy, my testimony will focus on the changing nature of the program. In my work with states, I see a dynamic program that is evolving to meet the changing needs of vulnerable populations, leading change in how care is structured and delivered, and participating in the transformation of care delivery and financing that is occurring around the country.

Health Care. National Academies Press, Washington (DC). 2009. Accessible from: http://www.iom.edu/Reports/2009/Americas-Uninsured-Crisis-Consequences-for-Health-and-Health-Care.aspx

[7] DeLeire, T., Dague, L., Leininger, L., Voskuil, K., Friedsam, D. Wisconsin Experience Indicates That Expanding Public Insurance to Low-Income Childless Adults Has Health Care Impacts. Health Aff(Millwood). 2013 Jun. 32(6):1037-1045. Accessible from: http://content.healthaffairs.org/content/32/6/1037.full

[8] Institute of Medicine, "America's Uninsured Crisis."

[9] Sommers, B., Baicker, K., Epstein, A. Mortality and Access to Care among Adults after State Medicaid Expansions. New England Journal of Medicine, 13 Sept 2012: 367:1025-1034. Available from from http://www.nejm.org/doi/full/10.1056/NEJMsa1202099#t=articleMethods

Meeting the Needs of the Medicaid Population

In this first section of my testimony I discuss steps Medicaid is taking to address the particular needs of the population it serves. The areas I discuss represent just a few examples of the kind of innovation that occurs continually within the Medicaid program. The areas I will focus on are developmental screening, oral health, long term services and supports, and eligibility streamlining.

Developmental Screening

As the source of insurance coverage for one of every three children, Medicaid has a particular interest in assuring that children with developmental delays or at risk of delay are identified and receive needed services. The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 required the development of a core set of quality measures for child health. Released in early 2011, one of the core measures is the percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool at certain ages.

Research suggests that many health problems and disorders in children could be prevented or ameliorated with prevention, early detection, and intervention. Prevention and early intervention efforts targeted to children, youth and their families have been shown to be beneficial and cost-effective and reduce the need for more costly interventions and outcomes such as welfare dependency and juvenile detention. Evidence also indicates that pediatric primary care providers who use a standardized, validated,

developmental screening tool more effectively identify children at risk for developmental delay than those who rely solely on medical judgment.[10]

Medicaid has led the way in promoting the use of valid screening methods to identify children who would benefit from early intervention services. The percentage of children receiving such screening has grown from 19.5 percent in 2007 to 30.8 percent in 2011-12, with improvement in every state but one.[11] Medicaid policy has played a critical role, with fourteen states requiring Medicaid providers to perform a standardized developmental screening as part of certain well-child exams. In twenty-six states, the Medicaid program pays an additional fee for standardized screening. Some states reimburse for more than one type of screen during a well-child visit (e.g. mental health, parental depression, autism).

North Carolina leads the nation in developmental and behavioral health screenings for children ages birth to five. Seventy-five percent of Medicaid well-child exams for children in this age range include a developmental screen, and the state requires the use of standardized screening tools during specific well-child visits in order to receive Medicaid reimbursement.

North Carolina began by implementing screening through its Community Care of North Carolina (CCNC) networks. Oklahoma is pursuing changes that will make developmental screening and follow-up a requirement for all three tiers of medical home recognition in the state. Oregon has made developmental screening a "must pass element" in its revised Patient Centered Primary Care Homes (PCPCH) standards to be

[10] D. Rydz, et al. "Developmental Screening," J Child Neurol. 2005; 20(1): 4-21.
[11] Child and Adolescent Health Measurement Initiative, Data Resource Center for Child & Adolescent Health, "Newsletter, April 9, 2013." (Retrieved April 10, 2013).

released in October 2013 and an incentive metric for its Coordinated Care Organizations (CCOs).[12]

Medicaid is not only leading in policy; it is leading in outcomes. Children with public health insurance are now more likely to receive a developmental screen than children with private health insurance.[13]

Oral Health

In 2000, Surgeon General David Satcher called poor oral health America's silent epidemic.[14] State Medicaid programs are actively pursuing efforts to ameliorate this crisis for the vulnerable populations they serve.

For example, North Carolina's *Into the Mouths of Babes* program pioneered the use of Medicaid funding to encourage doctors and nurses (who children are more likely to see than a dentist) to provide oral screenings and fluoride varnish to very young children, as soon as their first teeth erupt.[15] Evaluations have shown the *Into the Mouths of Babes* program is cost-effective in preventing decay, reducing the number of children who must be treated in a hospital for extensive decay, and improving a child's likelihood

[12] Information about state approaches to improving developmental screening can be found at http://www.nashp.org/abcd-welcome.

[13] The Data Resource Center for Child and Adolescent Health, a project of the Child and Adolescent Health Measurement Intiative. 2007 National Survey of Children's Health: Question 4.16: Developmental Screening During Health Care Visit, age 10 months – 5 Years by Type of Insurance. Accessed June 18, 2012. Available from: http://www.childhealthdata.org/browse/survey/results?q=257&g=74

[14] U.S. Department of Health and Human Services. Oral Health in America: A Report of the Surgeon General. Rockville (MD): U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000. Accessible from: http://silk.nih.gov/public/hck1ocv.@www.surgeon.fullrpt.pdf

[15] Snyder, A. "Increasing Access to Dental Care in Medicaid: Targeted Programs for Four Populations. National Academy for State Health Policy, March 2009. Accessible from: http://nashp.org/publication/increasing-access-dental-care-medicaid-targeted-programs-four-populations.

of being seen by a dentist for routine care.[16] This innovative practice has spread across the country, with forty-four state Medicaid programs following suit by 2013.[17]

Washington's *Access to Baby and Child Dentistry* program is a long-standing, successful partnership between Medicaid, counties, and local dental associations in which enhanced Medicaid payments are made to general dentists who receive specialized training and agree to treat children under the age of five. This very successful initiative helps provide timely preventive care to children at high risk of dental decay. Between 1997 and 2004, the number of Medicaid-enrolled children receiving dental care more than doubled, and the number of children under age two who received care more than quadrupled.[18]

Maryland responded to the tragic death in 2007 of a child from a brain infection resulting from untreated dental caries with a comprehensive set of dental policy changes, including Medicaid payment rate increases, administrative streamlining, and enhancements to public health programs.[19] Since then, the state has experienced a marked improvement in children's access to dental care, with use of preventive dental

[16] Stearns, S. et. al. Cost-Effectiveness of Preventive Oral Health Care in Medical Offices for Young Medicaid Enrollees. Archives of Pediatric & Adolescent Medicine 2012; 166(10): 945-951. Accessible from: http://archpedi.jamanetwork.com/article.aspx?articleid=1355373.

[17] American Academy of Pediatrics. State Medicaid Payment for Caries Prevention Services by Non-Dental Professionals. (updated June 2013). Accessible from: http://www2.aap.org/oralhealth/docs/OHReimbursementChart.pdf.

[18] Pew Center on the States. Washington's ABCD Program: Improving Dental Care for Medicaid-Insured Children. Washington (DC): The Center. 29 Jun 2010. Accessible from: http://www.pewstates.org/research/reports/washingtons-abcd-program-85899373157.

[19] Maryland Dental Action Coalition. Maryland Oral Health Plan, 2011-2015. 2011. Accessible from: http://www.mdac.us/maryland-oral-health-plan/.

services among Medicaid-enrolled children rising by nineteen percentage points between 2007 and 2011.[20]

While dental access for children in Medicaid lags behind children with private health insurance, CMS reports that between fiscal years 2007 and 2011, twenty-four states achieved a ten percentage point increase in the proportion of children with a preventive dental visit.[21] These improvements reflect continued efforts by states to tackle the persistent challenge of low-income children's access to oral health care.[22]

Long-Term Services and Supports (LTSS)

As the nation's primary payment source for long-term services and supports, Medicaid policy largely defines how low-income elders and people with disabilities receive skilled nursing services, residential services, and supports for activities of daily living. From 1999 to 2009, the share of Medicaid LTSS spending devoted to home and community based services for older people and adults with physical disabilities increased from 18.6 percent to 35.1 percent. States continue to shift their Medicaid long-term services and supports expenditures from nursing facility care to home and community-based services. This shift promotes human dignity and saves money.

For more than two decades, Washington has been leading the way providing long-term services and supports in the community, enabling older adults and individuals with disabilities to have choices about where they live, what services they receive, and who

[20] Centers for Medicare and Medicaid Services. CMS Oral Health Initiative and Other Dental-Related Items, CMCS Informational Bulletin 04-18-13. 18 Apr 2013. Accessible from: http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-04-18-13.pdf

[21] Ibid.

[22] See, for example, Government Accountability Office. Efforts Under Way to Improve Children's Access to Dental Services, but Sustained Attention Needed to Address Ongoing Concerns, GAO-11-96. Washington (DC): GAO. 30 Nov 2010. Accessible from: http://gao.gov/products/GAO-11-96.

provides their services. By offering a wide range of services, avoiding waiting lists for in-home care, and expediting services, the state has been successful at diverting individuals from institutions. Washington has one of the most balanced long-term services and supports systems in the nation, with three-quarters of individuals receiving services in the community, rather than in institutions, and sixty-two percent of its long-term services and supports budget spent on home and community-based services.

Washington has actually reduced the number of persons residing in nursing facilities. The state has been successful in transitioning individuals out of nursing homes and back into the community by assigning case managers to develop and implement transition plans. Washington works not only with those who have just arrived in a nursing home, but also those who have been resident for an extended period, who require a more comprehensive set of supports to return to the community. Between 2005 and 2010, Washington decreased the number of Medicaid supported nursing facility residents by six percent.[23]

Eligibility Streamlining

Medicaid eligibility was built on a welfare application platform, which presents significant barriers for busy families unable to take unpaid time to wait in line to enroll and requires a large bureaucracy for administration. Taking advantage of opportunities created by the delinking of Medicaid from welfare in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (commonly known as welfare reform) and the creation of the State Children's Health Insurance Program in 1997, states have made

[23] AARP. Across the States: Profiles of Long-Term Services and Supports. 2012. Accessible from: http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2012/across-the-states-2012-full-report-AARP-ppi-ltc.pdf.

major strides in simplifying their eligibility processes to improve customer service and so the program can better serve those who meet eligibility standards.

Before they were required to take these steps by the Affordable Care Act, states were moving away from administratively burdensome requirements like face-to-face interviews and asset tests and embracing innovations such as presumptive eligibility, allowing for continuous eligibility regardless of income fluctuations, and borrowing data from programs like SNAP to determine eligibility more efficiently. States are relying on new technologies to make Medicaid enrollment a more modern, 21st century experience. Some states already use electronic case records, allow electronic verification of eligibility and information sharing across programs, and allow individuals to update their information using a consumer-facing personal account. Nearly all states are using new, enhanced federal matching funds to upgrade their antiquated computer systems.

In 2010, Louisiana became the first state to implement Express Lane Eligibility. The Department of Health and Hospitals partners with the Department of Children and Family Services to use SNAP eligibility determinations to automatically enroll and renew children's Medicaid coverage.

Also in 2010, Oklahoma launched the nation's first online, real-time enrollment system for Medicaid, which can accept applications, generate documentation requests, make determinations, and enroll individuals into a plan 24 hours a day, 7 days a week. Oklahoma's automated system allows eighty-two percent of applicants to enroll when they apply, with about half of those applicants required to submit additional documentation that confirms their eligibility. The automated system offers a particular benefit to busy families: in 2011, one-quarter of online applications were submitted in the

evenings after 5 p.m. or on weekends.[24] The eligibility system has been able to maintain operations even when state offices are closed. For two days in February 2011, most of Oklahoma's agencies were closed due to a blizzard, but the automated system continued operations, enrolling 780 individuals.

Integration with Other Systems

Medicaid is increasingly working with other public and private systems to promote better health outcomes and a more efficient, better organized health care system. In this section I review six examples of these interdisciplinary approaches: managed care, patient-centered medical homes, health homes, integration with public health, accountable care models, and the State Innovation Models program.

Medicaid Managed Care

All but three states rely upon managed care for delivering care to at least some of their Medicaid enrollees. Two-thirds of Medicaid enrollees receive most or all of their benefits in managed care. Recent trends are toward greater reliance upon mandatory Medicaid managed care programs for more complex populations, such as children with special health care needs and people of all ages with disabilities. Half the states have voluntary or mandatory programs that enroll individuals who are dually eligible for Medicare and Medicaid into a managed care program.[25]

States' use of managed care reflects a desire to achieve cost savings and budget predictability. These programs enable states to tap into care management strategies developed in the private sector. Managed care plans have data systems that gather

[24] Turner T., Online enrollment [PowerPoint Presentation]. Oklahoma Healthcare Authority; 2012.
[25] Kaiser Family Foundation, "Medicaid Managed Care: Key Data, Trends, and Issues," (February 2012).

quality and utilization information that helps states monitor and improve program performance. While these programs have been controversial in some instances, they reflect a desire by states to utilize care coordination and care management methods and move away from Medicaid's fee-for-service history.

Patient-Centered Medical Homes

Medicaid has been a leader in promoting development of patient-centered medical homes, recognizing that strong primary care systems are the backbone of high performing health systems. Over the past seven years, states have been redesigning Medicaid to deliver better primary care through the medical home model, an enhanced model of primary care that provides whole person, accessible, comprehensive, ongoing and coordinated patient-centered care. Since 2006, twenty-nine states have launched one or more programs in Medicaid or the Children's Health Insurance Program, which offer new medical home payments and supports to primary care providers to deliver higher quality, more accessible, patient-centered care. In eighteen of these states, public and private payers and purchasers are working together to support multi-payer medical home projects, aligning objectives and incentives to spur system-wide transformation. Fifteen of these initiatives also include Medicare.

For example, in Michigan, Medicaid and Blue Cross Blue Shield have teamed up with Medicare to launch one of the largest medical home programs in the country, reaching over 1,000,000 patients. Maine's patient-centered medical home pilot includes ten multi-disciplinary community care teams serving multiple primary care practices. Maine is building on this critical infrastructure as it pursues additional payment and delivery system reforms, including health homes and community-driven accountable care

organizations. Maryland's multi-payer patient-centered medical home program serves 250,000 patients across Medicaid and the state's five largest commercial payers. Participating practices achieved significant savings in the program's first year. The state announced in October 2012 that twenty-three of the fifty-two participating practices received shared savings payments for containing costs while meeting program quality standards.[26]

Health Homes

The health home model is an extension of the medical home that focuses on chronically ill Medicaid enrollees. Twelve states have received approval to implement health home programs under Section 2703 of the Affordable Care Act.[27] Health homes integrate physical health, behavior health, and long-term services and supports to meet the needs of the most complex populations.

States are using health home programs to design comprehensive, person-centered programs that best fit the needs of their high-risk, high-cost populations. Many states have successfully leveraged the existing medical home and primary care case management infrastructure already built in their state. Others have used the program to serve as a platform for future delivery reforms.

For example, New York phased in a statewide health home program that required providers to apply as a larger team with other providers in their community, strengthening or formalizing partnerships across the health care continuum and ensuring

[26] Comprehensive information regarding state efforts to support patient-centered medical homes can be found at http://nashp.org/med-home-map.
[27] http://www.integratedcareresourcecenter.com/hhstateresources.aspx.

that the spectrum of health and psychosocial needs of a patient could be met.[28] Washington recently received approval of its health home state plan amendment, which serves as a foundation for the state's Financial Alignment for Medicare-Medicaid Enrollees Demonstration.

Integrating Health Care Services and Public Health

Efforts to improve population health can be more effective if they blend personal health care services with public health interventions. Campaigns to reduce smoking offer an excellent opportunity to integrate these approaches.

Massachusetts provides an instructive example. In 2006, Massachusetts' health reforms included the addition of a smoking cessation benefit to the state's Medicaid program. At the time, Massachusetts was one of only six states to include smoking cessation as a Medicaid benefit. In Massachusetts, Medicaid enrollees can obtain up to two 90-day regimens of smoking cessation medications per year, although higher levels are permitted with preauthorization. The medications are available by prescription (by a doctor, nurse practitioner or physician assistant), and copayments are nominal. Counseling is available, with up to sixteen sessions per year, including two intake/assessment sessions and fourteen counseling sessions (with more available with preauthorization), in the form of individual or group sessions. Since in-person counseling is not available statewide, participants can also use telephone counseling services, including Quitworks, a program offered by the Massachusetts Department of Public Health. These services are also available from all Medicaid managed care plans and some plans offer additional benefits.

[28] http://www.chcs.org/usr_doc/2012-12-11_spa_approval_plan_pgs_%28phase_III%29.pdf.

Simultaneous with the inclusion of this new Medicaid benefit, the public health department launched a campaign to publicize the availability of the smoking cessation benefit. The campaign included radio and transit advertising and community outreach. In the first two years, forty percent of Medicaid enrollees in Massachusetts took advantage of the smoking cessation benefit. As a result, smoking prevalence among Medicaid enrollees dropped twenty-six percent in two years.

Costly medical procedures among those who utilized the cessation benefit also fell dramatically. Among benefit users, there were thirty-eight percent fewer hospitalizations for heart attacks and seventeen percent fewer emergency-room visits for asthma symptoms in the first year after using the benefit. There were seventeen percent fewer claims for maternal birth complications since the benefit was implemented, state health officials reported. The state saved $3 for every $1 that was spent on the smoking cessation program.[29]

Accountable Care

Medicaid programs around the country are pursuing new models of accountable care that encourage health care providers to organize and coordinate care as they accept financial risk and accountability for health outcomes. Some states are building their models directly on the Accountable Care Organizations authorized by the Medicare program. Other states are developing approaches tailored to meet the specific needs of the state and the state's Medicaid population.

[29] Comprehensive information regarding the Massachusetts program can be found at http://www.mass.gov/dph/mtcp.

For example, New Jersey is launching a Medicaid Accountable Care Organization Demonstration Project in which groups of providers will assume responsibility for Medicaid populations within a designated geographic area under a shared savings payment model. Minnesota's Health Care Delivery Systems Demonstration will reward groups of Medicaid-participating providers and integrated delivery systems that can achieve savings below a total cost of care target while meeting quality performance requirements. Illinois is recognizing new collaborations of health care providers and community agencies called Care Coordination Entities that will assume financial risk for delivering a package of Medicaid services to enrolled beneficiaries.

Other states are using accountable care principles to develop innovations in their Medicaid programs. Colorado rolled out seven Regional Care Collaborative Organizations (RCCOs) that are responsible for providing medical management, care coordination, and support to Medicaid providers that function as medical homes. RCCOs and primary care providers can receive incentive payments based on performance on select quality indicators. Oregon has built upon a robust patient-centered medical home infrastructure to launch a statewide network of Coordinated Care Organizations (CCOs)—new health plans that secure integrated and coordinated health care for Oregon Health Plan enrollees under global budgets. CCOs are expected to move beyond fee-for-service payment mechanisms for compensating health care service providers, implementing alternative payment methodologies that are based on health care quality and improved health outcomes.[30]

[30] Additional information regarding state approaches to develop accountable care models can be found at http://www.nashp.org/state-accountable-care-activity-map.

State Innovation Models

Twenty-five states have received support to test or further develop comprehensive, multi-payer payment and delivery system reforms through Centers for Medicare and Medicaid Innovation's State Innovation Models cooperative agreements. These states are pursuing the shared aim of better care and improved population health at lower cost, using reforms of their Medicaid programs as a catalyst for broader system improvements.

For example, Vermont's SIM approach includes the use of Community Health Teams and Support Services at Home programs, and is seeking to integrate mental health with medical services. Arkansas is focusing on a population-based care delivery model. In Arkansas' medical homes, each patient will be supported by a constellation of providers who address their complete health needs. Health homes will provide additional support to individuals with special needs. Patients will be managed by a "quarterback" provider who assumes responsibility for management of acute and chronic conditions. Minnesota organizes providers who are not formally integrated into "virtual ACOs" by aligning financial arrangements and creating a shared clinical information system. Minnesota's model seeks to integrate medical care, mental/chemical health, community health, public health, social services, schools and LTSS, and encourages providers to partner with community organizations to manage population health.

Conclusion

Medicaid's federalist structure is a source of tension, but also strength. Medicaid is costly, which reflects the profound needs of people vulnerable due to poverty and poor

health. Medicaid is imperfect and suffers from many of the same shortcomings as the rest of the American health care system. But I am unaware of any proposal to replace or fundamentally change the program that holds promise for better meeting the needs of the most vulnerable Americans. Indeed, those who propose major changes to Medicaid should subject their proposals to the same scrutiny they apply to the current program.

As states choose whether or not to expand their Medicaid programs, Congress should be aware that the program they have authorized is dynamic and evolving to meet the needs of the most vulnerable Americans. Americans who are without health insurance seek access to care and to be treated with dignity, just like anyone else. While the nation debates the future of Medicaid and the future of the health care system, Medicaid is the only practical option millions of vulnerable Americans have for meeting their health care needs. Medicaid works for the most vulnerable.

I greatly appreciate the opportunity you have given me to offer this testimony.

Mr. PITTS. And now recognize Mr. Bragdon for 5 minutes for an opening statement.

STATEMENT OF TARREN BRAGDON

Mr. BRAGDON. Thank you, Mr. Chairman, members of the committee. I serve as the CEO of the Foundation for Government Accountability. We are a Naples, Florida-based free market think tank specializing in State health and welfare policy solutions.

Medicaid in its current form, or Old Medicaid, represents, as you have heard, the single largest and fastest growing line item in State budgets, consuming about one in four State dollars. At the Federal level, Medicaid spending represents about a quarter of deficit spending and is projected to double over the next decade.

Given these cost projections, Medicaid is failing the American taxpayer. But more importantly, it is failing the patients that it is supposed to represent. Poor access to specialists, the inability to personalize care, and perverse eligibility requirements keep too many Americans poor and sick and rob them of the hope of a better life. And for many Americans, Old Medicaid is not a safety net, but it is a tightrope, and patients are falling off every day.

Because of the Affordable Care Act, many States are debating whether or not they should expand their broken Old Medicaid systems. This debate is a misguided priority. The real priority for States should be not expansion, but rather to make Medicaid work for the most vulnerable. And Congress can help State leaders by creating more flexibility at the Federal level to do that.

When States have flexibility to innovate and reform Old Medicaid, truly patient-centered care can be a reality. And one of the many pro-patient strategies working in the States are giving Medicaid patients the power to choose from several different competing private plans. Old Medicaid typically forces patients into one or two government-run plans, and this government-centered approach ignores that Medicaid patients have unique needs and individual concerns. But in States where Medicaid patients have a robust choice of plans, such as Florida, Kansas, and Louisiana, patients are our priority. For example, in Florida's Medicaid Reform Pilot, patients can choose from 13 different private plans and 31 different customized benefit packages. A commonsense funding formula in these States features risk-adjusted capitated rates so these private plans earn more money to enroll sicker patients and have the incentives to improve health and disincentives to cherry-pick.

Because plans compete for patient enrollment, they also are constantly striving to improve access to specialists, offer more specialized services, and enhance their customer service. And patients like this choice, with 70 to 80 percent of Medicaid patients proactively choosing a plan rather than being automatically assigned to one.

This choice structure also promotes better health outcomes. Again, in Florida's Reform Pilot, the private plans in the reform outperformed Old Medicaid on 22 of 33 widely tracked health outcomes, and 94 percent of those health outcomes had improved since 2008. And when this reform goes statewide in Florida, taxpayers will save a billion dollars a year. And similar savings are occurring in Kansas—a billion over 5 years—and Louisiana—$150 million in the first year. My written testimony includes details of other strat-

egies that States have embraced, including integrating work with health outcomes, promoting specialty plans, and unleashing innovation to better serve patients.

But Federal rules and regulations can make it difficult for States to innovate, including the slow and inflexible waiver process, new taxes on private Medicaid plans, and additional cost shifts to the States. Luckily, this committee is exploring ways that Congress can make State reform easier and grant additional flexibility, and many of these reforms are detailed in my testimony, including allowing proven waivers to become seamlessly incorporated into State plan amendments, providing greater flexibility on mandatory and optional services, and creating an off-ramp that lets patients safely transition off Medicaid toward self-sufficiency in the hope of a better life.

To make Medicaid work for the most vulnerable, Congress should recognize that proven pro-patient, pro-taxpayer solutions are out there. And there are strategies that can make it easier for State leaders and for patients to make Medicaid work for both patients and taxpayers. And I am happy to discuss that more in the questions. Thank you.

Mr. PITTS. The chair thanks the gentleman and thanks the witnesses for their opening statements.

[The prepared statement of Mr. Bragdon follows:]

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Committee on Energy and Commerce
Subcommittee on Health

Making Medicaid Work for the Most Vulnerable

July 8, 2013

Tarren Bragdon
President and Chief Executive Officer
Foundation for Government Accountability

I am Tarren Bragdon and serve as the President and CEO of the Foundation for Government Accountability. The Foundation is a free-market think tank specializing in health and welfare policy solutions and is based in Naples, Florida. Thank you for the opportunity to testify on this critical issue.

Medicaid currently represents the single largest and fastest growing line item of state budgets.[1] Medicaid spending already represents one-fourth of the federal deficit and federal Medicaid spending is expected to more than double during the next decade.[2] This spending growth is nearly twice as fast as the expected growth in the economy.[3]

But more importantly, Medicaid is failing patients by keeping too many people poor and sick, and robbing them of the hope of a better life. States are currently debating whether or not to expand this broken Old Medicaid program, but that should not be the priority. The priority for states should be to make Medicaid finally work best for patients and taxpayers.

Some states are leading the way. Here are a few strategies that are working well for patients, providers, policymakers and taxpayers:

1. Empowering Medicaid patients with meaningful choices. States such as Florida, Kansas and Louisiana have empowered Medicaid patients to choose the health plans that work best for them. In Florida, for example, patients can choose from up to 13 different health plans offering 31 different and customized benefit packages.[4]

When given meaningful choices and adequate, objective information, Medicaid patients take more control over their health. In Florida's Reform Pilot and in Louisiana's Bayou Health, for example, independent choice counselors assist Medicaid patients in navigating the plan selection process, providing neutral comparisons based on patients' specific needs and concerns.[5-6]

As a result, between 70 percent and 80 percent of patients in Florida's Reform Pilot actively choose their health plan, compared to the 20 percent to 30 percent who let the state automatically

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[1] Brian Sigritz, "State expenditure report: Examining fiscal 2010-2012 state spending," National Association of State Budget Officers (2012), http://www.nasbo.org/sites/default/files/State%20Expenditure%20Report_1.pdf.
[2] Christina Hawley Anthony et al., "The budget and economic outlook: Fiscal year 2013 to 2023," Congressional Budget Office (2013), http://www.cbo.gov/sites/default/files/cbofiles/attachments/43907-BudgetOutlook.pdf.
[3] Ibid.
[4] Florida Agency for Health Care Administration, "Florida Medicaid reform: Year 6 annual report," Florida Agency for Health Care Administration (2012), http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/FL_1115_YR_6_Final_Annual_Report_07-01-11_06-30-12.pdf.
[5] Florida Agency for Health Care Administration, "Florida Medicaid reform: Year 6 annual report," Florida Agency for Health Care Administration (2012), http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/Fl_1115_yr_6_Final_annual_report_07-01-11_06-30-12.pdf.
[6] Medical Vendor Administration, "Request for proposals: Enrollment broker for Louisiana Medicaid coordinated care networks, RFP # 305PUR-DHHRFP," Louisiana Department of Health and Hospitals (2011), http://new.dhh.louisiana.gov/assets/docs/Making_Medicaid_Better/RequestsforProposals/enrollbroker/EB_RFP_FINAL.pdf.

assign them to a plan.[7] In Louisiana, approximately 70 percent of new Medicaid patients actively choose their health plan.[8] Choice counseling programs ensure patients are empowered not only with the ability to choose, but with the knowledge necessary to choose wisely.

This active participation and plan selection illustrates that, when given the power to choose and the information necessary to make an educated decision, patients want to take more responsibility over their health future. In Kansas, for example, American Indians were allowed to opt out of the reforms that offered them a choice of multiple private plans and instead remain in traditional Old Medicaid. But since the reforms launched in January 2013, just 12 American Indians chose to opt out of the reforms and return to Old Medicaid.[9]

The competition among plans has resulted in those plans constantly striving to innovate, improve customer service and maximize the offered benefits and rewards. Costs for these reformed benefit packages have been substantially below spending for similar populations statewide.[10] Florida expects to save nearly $1 billion annually when the reforms are phased in statewide.[11] This example highlights how states are able to deliver more choices to Medicaid patients and still save precious taxpayer dollars.

These customized benefit packages are not only delivering greater choice, they are delivering better results as well. The plans offered in Florida's Reform Pilot outperformed the traditional Old Medicaid program on 22 of 33 widely-tracked health outcomes.[12] Better yet, 94 percent of the Reform Pilot's regularly-tracked health performance measures have improved since 2008.[13] Implementing a robust Medicaid marketplace, where patients choose the health plan that works best for them, has increased access to needed care, improved health outcomes, provided patients with greater satisfaction with the quality of the care and service they receive, and lowered costs for taxpayers.

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[7] Florida Agency for Health Care Administration, "Florida Medicaid reform: Year 6 annual report," Florida Agency for Health Care Administration (2012), http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/Fl_1115_yr_6_Final_annual_report_07-01-11_06-30-12.pdf.

[8] Between January 2013 and May 2013, approximately 56,000 of the 82,000 newly eligible Bayou Health patients made pro-active choices about which health plan in which to enroll. See, e.g., Maximus, "New enrollment by Medicaid eligibility group and health plan," Louisiana Department of Health and Hospitals (2013), http://dhh.louisiana.gov/index.cfm/page/1391.

[9] Division of Health Care Finance, "Quarterly report to CMS regarding operation of 1115 waiver demonstration program: Quarter ending March 31, 2013," Kansas Department of Health and Environment (2013), http://www.kancare.ks.gov/reports/KanCare_Quarterly_Report_QE_3_31_13.pdf.

[10] Tarren Bragdon, "Florida's Medicaid reform shows the way to improve health, increase satisfaction and control costs," Heritage Foundation (2011), http://www.medicaidcure.org/wp-content/uploads/2012/09/Medicaid-Cure-Floridas-Medicaid-Reform-Pilot.pdf.

[11] Ibid.

[12] Florida Agency for Health Care Administration, "Florida Medicaid reform: Year 7, 2nd quarter progress report," Florida Agency for Health Care Administration (2012), http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/Fl_1115_Q2_yr_7_report_10-1-2012_12-31-2012_final.pdf.

[13] Ibid.

2. Integrating work with health outcomes. Kansas has created two unique employment-focused pilot programs that integrate work with health outcomes for individuals with developmental disabilities. The first pilot, which covers individuals receiving SSI who are on the waiting list to receive home and community-based services, provides assistance with obtaining employment and provides up to $1,500 per person per month in employment support services.[14] The second pilot focuses on youth and those who would likely meet the criteria for Social Security Disability but are not yet receiving it. These individuals receive employment assistance focused on jobs with employer-sponsored health coverage and receive wrap-around Medicaid services once enrolled in a work-related health plan.[15]

By integrating employment into Medicaid, KanCare can help these individuals gain opportunities to maintain and improve their skills, helping lead to long-term employment and productivity. Given the strong association between employment and better health, integrating employment services also helps to avoid the culture of poverty, poor health and social isolation stemming from lack of employment.[16]

3. Innovation through private plans. States have also been able to harness, through contracted private plans, innovations which improve quality and reduce costs. By allowing health plans to offer customized and extra benefit packages, states can provide patients with benefits not typically covered by the traditional Old Medicaid program, but which have profound effects on health outcomes. In 2012, plan providers in Florida's Reform Pilot offered 31 different benefit packages, with coverage for over-the-counter drugs, vision, preventive dental coverage, nutrition therapy and respite care included among the value-added extra benefits.[17] In Kansas, individuals can choose plans that offer additional dental benefits, smoking cessation programs, GED programs, Weight Watchers membership and Boys and Girls Clubs membership, among other benefits.[18] Customized and enhanced benefit packages ensure that health plans are able to compete on value by tailoring their benefits to best meet the needs and desires of their patients.

This customization is most evident for patients with very complicated health challenges. In Florida's Reform Pilot, for example, these patients are offered specialty plans tailored to their unique needs. This includes plans developed specifically for medically fragile children and plans customized to best manage HIV/AIDS.[19] Kansas offers programs that are specifically designed

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[14] Division of Health Care Finance, "KanCare: Section 1115 demonstration waiver," Kansas Department of Health and Environment (2013), http://www.kancare.ks.gov/download/KanCare_Section_1115_Demonstration_August_6_2012.pdf.
[15] Ibid.
[16] Ellie C. Hartman, "A literature review on the relationship between employment and health: How this relationship may influence managed long term care," Wisconsin Department of Health Services (2008), http://www.dhs.wisconsin.gov/wipathways/ResearchDocs/litrevw.pdf.
[17] Florida Agency for Health Care Administration, "Florida Medicaid reform: Year 6 annual report," Florida Agency for Health Care Administration (2012), http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/Fl_1115_yr_6_Final_Annual_Report_07-01-11_06-30-12.pdf.
[18] Division of Health Care Finance, "Medicaid for Kansas: Choosing a KanCare health plan," Kansas Department of Health and Environment (2013), http://www.kancare.ks.gov/choosing_a_plan.htm.
[19] Ibid.

to help manage complicated conditions such as HIV/AIDS and schizophrenia.[20] Specialty plans ensure that patients with complicated health challenges can receive the unique care they deserve.

Private plan innovation is not just occurring in plan customization. Private plans are also innovating wellness programs. These wellness programs adopt incentive structures that reward Medicaid patients for healthy behavior. Patients in Florida's Reform Pilot plans can earn up to $125 per year for receiving certain preventive services, complying with maintenance and disease management programs, keeping appointments and engaging in other healthy behaviors.[21] Individuals may then use these rewards to purchase over-the-counter items at participating pharmacies.[22] In Kansas, patients can choose plans that offer cash incentives for healthy behaviors, such as getting vaccinations, regular checkups and the like.[23]

This kind of wellness program further encourages Medicaid patients to take control of their own health by offering financial incentives for engaging in healthy behaviors. Similar wellness rewards programs operate through contracted Medicaid managed care organizations in Arizona, Georgia, Illinois, Indiana, Kentucky, Louisiana, Massachusetts, Missouri, Mississippi, New Hampshire, Ohio, South Carolina, Texas, Washington and Wisconsin.

In Ohio, for example, patients can earn up to $175 for preventive services and disease management. Pregnant mothers may earn up to $100 for completing regular prenatal visits and parents can earn another $100 for completing regular well-child visits. In South Carolina, parents can earn an extra $105 just for completing regular well-child visits.

But not all programs are innovating. Here are a few things that are not working:

1. Perverse funding formulas. Under the Patient Protection and Affordable Care Act, states that choose to expand Medicaid coverage will receive an enhanced matching rate for the new Medicaid population.[24] This population consists primarily of able-bodied adults without children and low-income parents.[25] The enhanced matching rate for the newly eligible population starts at 100 percent in 2014 and then gradually reduces to 90 percent by 2020.[26]

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[20] Division of Health Care Finance, "KanCare: More choices, better access, healthy patients," Kansas Department of Health and Environment (2013), http://www.kancare.ks.gov/download/KanCare_ProPatient_ProTaxpayer.pdf.

[21] Florida Agency for Health Care Administration, "Florida Medicaid reform: Year 6 annual report," Florida Agency for Health Care Administration (2012), http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/Fl_1115_yr_6_Final_annual_report_07-01-11_06-30-12.pdf.

[22] Ibid.

[23] Division of Health Care Finance, "Medicaid for Kansas: Choosing a KanCare health plan," Kansas Department of Health and Environment (2013), http://www.kancare.ks.gov/choosing_a_plan.htm.

[24] 42 U.S.C. § 1396d(y).

[25] Genevieve M. Kenney et al., "Opting into the Medicaid expansion under the ACA: Who are the uninsured adults who could gain health insurance coverage?" Urban Institute (2012), http://www.urban.org/UploadedPDF/412630-opting-in-medicaid.pdf.

[26] 42 U.S.C. § 1396d(y).

The matching rate for currently eligible individuals, on the other hand, ranges from 50 percent to 83 percent, with the federal government typically paying an average of 57 percent of Medicaid expenditures.[27] This means that states will receive less federal support to provide services to the most vulnerable; those patients currently eligible for Medicaid, including the elderly, individuals with disabilities and children. This perverse funding formula provides states with incentives to cut services and benefits for the most vulnerable, giving preferential treatment to adults without any disabilities or dependent children.

There are more than 511,000 individuals on waiting lists to receive home and community-based services through Medicaid.[28] Those on waiting lists include individuals with intellectual disabilities, developmental disabilities, traumatic brain and spinal cord injuries, physical disabilities, mental health conditions and HIV/AIDS.[29] The Medicaid expansion's perverse funding formula ensures these individuals will be kicked to the end of the line in order to provide coverage to able-bodied adults in the states that opt to expand.

2. A too expansive, broken program. When broken Old Medicaid programs become too expansive, states often delay payments to doctors, hospitals and other providers in order to make ends meet. For example, Illinois owed doctors, hospitals and other medical providers more than $2 billion for unpaid Medicaid services at the end of fiscal year 2012.[30] The average medical provider waited more than 5 months to receive reimbursement for their services, with some delays lasting eight months or more.[31-32] These reimbursement delays occurred despite federal law requiring states to pay 90 percent of Medicaid bills within 30 days and 99 percent within 90 days.[33]

Earlier this year in Maine, a coalition of 39 hospitals demanded $484 million for unpaid Medicaid bills dating back to 2009.[34] The hospitals went so far as to launch radio and newspaper advertisements to build public pressure on state policymakers to pay down the backlog of Medicaid bills. Of course, Maine expanded Medicaid eligibility to able-bodied adults without

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[27] 42 U.S.C. § 1396d(b).
[28] Kaiser Commission on Medicaid and the Uninsured, "Waiting lists for Medicaid section 1915(c) home and community-based service (HCBS) waivers," Kaiser Family Foundation (2013), http://kff.org/medicaid/state-indicator/waiting-lists-for-hcbs-waivers-2010/.
[29] Ibid.
[30] John Sinsheimer, "General obligation bonds, Series A and B of April 2013," Illinois Governor's Office of Management and Budget (2013), http://www.state.il.us/budget/ILState02a-FIN.pdf.
[31] Mallory Meyer et al., "State of Illinois budget summary: Fiscal year 2012," Illinois Commission on Government Forecasting and Accountability (2011), http://cgfa.ilga.gov/Upload/FY2012BudgetSummary.pdf.
[32] Jennifer Levitz and Louise Radnofsky, "Delays in Medicaid pay vex hospitals," The Wall St. Journal (2013), http://online.wsj.com/article/SB10001424127887324442304578234020690323296.html.
[33] 42 C.F.R. § 447.45(d)
[34] Jennifer Levitz and Louise Radnofsky, "Delays in Medicaid pay vex hospitals," The Wall St. Journal (2013), http://online.wsj.com/article/SB10001424127887324442304578234020690323296.html.

children in 2002.[35] Its Medicaid expansion far exceeded projected costs, forcing the state to cap enrollment in the program at various times and lengthen payment cycles to cope.[36]

Likewise, Arizona expanded Medicaid eligibility to childless adults in 2000.[37] But the expansion cost four times what was expected, forcing policymakers there to cut other areas in order to maintain the expansion.[38] Indeed, Arizona had to eliminate Medicaid coverage for heart, liver, lung, pancreas and bone marrow transplants in 2010 in order to pay for the growing costs of its Medicaid expansion.[39]

These payment delays and service cuts – emblematic of an expansive, broken program – ensure that Medicaid patients will face greater difficulty in finding doctors willing to treat them, likely resulting in worse health outcomes.

3. Slow, inflexible federal waiver processes. For many states, the waiver process is a long, drawn-out and complex negotiation with CMS. States face burdensome reporting requirements, subjective deadlines and general uncertainty about whether and when CMS will approve requested reforms. Even if a state receives a federal waiver to implement its desired reforms, the waiver lasts just three to five years.[40] After that time, it must either seek an optional extension of the waiver or submit a new waiver request altogether if it wants to continue its reforms. Even reform ideas that have proven effective elsewhere must follow this slow, inflexible process and states have no guarantee that the federal government will grant them permission to implement these effective reforms.

4. New taxes on private plans. The Affordable Care Act imposes a new $8 billion tax on private health plans, starting in 2014. This tax gradually increases to more than $14 billion in 2018, then increases at the annual growth in premiums. Strangely, this new tax also applies to Medicaid plans in states that have reformed their programs with managed care. Because the Medicaid managed care rates are required by federal law to be actuarially sound, the cost of this new tax will be borne by state and federal taxpayers. This results in a situation where the federal government is taxing both itself and states, increasing Medicaid costs and shifting more costs to the states.

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[35] Alexis Gibson, "MaineCare for childless adults: Section 1115 demonstration," Centers for Medicare and Medicaid Services (2011), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/me/me-childless-adults-fs.pdf

[36] Jonathan Ingram, "Medicaid expansion: We already know how the story ends," Foundation for Government Accountability (2013), http://www.medicaidcure.org/wp-content/uploads/2013/03/Medicaid-Expansion-We-Already-Know-How-the-Story-Ends-Medicaid-Cure-Policy-Brief-31.pdf.

[37] Jennifer Vermeer, "Ballot proposition 204, Healthy Arizona: Publicity pamphlet fiscal impact summary, revised Aug. 17, 2000," Arizona Joint Legislative Budget Committee (2000), http://www.azleg.gov/jlbc/ballotprop204.pdf.

[38] Jonathan Ingram, "Medicaid expansion: We already know how the story ends," Foundation for Government Accountability (2013), http://www.medicaidcure.org/wp-content/uploads/2013/03/Medicaid-Expansion-We-Already-Know-How-the-Story-Ends-Medicaid-Cure-Policy-Brief-31.pdf.

[39] Kevin Sack, "Arizona Medicaid cuts seen as sign of the times," New York Times (2010), http://www.nytimes.com/2010/12/05/us/05transplant.html.

[40] Section 1115 waivers are generally approved for five-year periods, Section 1915(b) waivers are generally approved for five-year periods and Section 1915(c) waivers are generally approved for three-year periods.

Nearly one-fifth of this new tax on private plans is expected to be borne by Medicaid programs.[41] The tax is expected to increase Medicaid capitated rates by up to 2.5 percent for some states, with the national average falling somewhere between 1.5 percent and 1.6 percent.[42] This amounts to between approximately $37 billion and $42 billion in increased Medicaid costs during the next ten years, with much of that added burden falling on state governments.[43] Adding a new tax on Medicaid plans will only accelerate the mayhem Medicaid programs are already creating for state budgets.

States are leading the way, implementing innovative solutions to the persistent problems Old Medicaid has created. But federal rules and regulations often hinder state leaders who want to make their Medicaid safety nets more responsive to patients, more accountable to policymakers and more affordable to taxpayers. Additional flexibility from the federal government should give each individual state the opportunity to build a Medicaid safety net to best serve patients and taxpayers.

A few recommendations to provide states with additional flexibility include:

1. Reject the one-size-fits-all expansion. Expanding Medicaid eligibility diverts scarce Medicaid resources away from the truly vulnerable in order to fund coverage for able-bodied adults. Prioritizing able-bodied adults above the elderly, individuals with disabilities and low-income children will only exacerbate the many problems present in Old Medicaid.

The various fiscal and health promises made by expansion supporters have already been broken in the states that have previously expanded eligibility to this group of people. They are likely to be broken in the states that opt into the Affordable Care Act's Medicaid expansion.[44] Medicaid expansion, including its perverse funding formula, should be rejected and states should regain their control over eligibility levels based on the needs, culture and values of their own state population.

2. Remove perverse funding dynamics. Under current law, states that implement innovative reforms see the majority of their savings go to the federal government, not to the states themselves. Under current Medicaid matching rates, states can expect to see only 17 percent to 50 percent of the savings their innovative reforms achieved. This creates a disincentive for states to make meaningful changes, as the lion's share of savings will accrue to the federal government.

The federal government could reduce this perverse funding dynamic by granting states flexibility and incentives to better share those savings. Doing so would promote innovation and provide

[41] John D. Meerschaert et al., "PPACA health insurer fee estimated impact on state Medicaid programs and Medicaid health plans," Milliman (2012), http://publications.milliman.com/publications/health-published/pdfs/ppaca-health-insurer-fee.pdf.
[42] Ibid.
[43] Ibid.
[44] Jonathan Ingram, "Medicaid expansion: We already know how the story ends," Foundation for Government Accountability (2013), http://www.medicaidcure.org/wp-content/uploads/2013/03/Medicaid-Expansion-We-Already-Know-How-the-Story-Ends-Medicaid-Cure-Policy-Brief-31.pdf.

states with a greater financial incentive to implement bold solutions. Although this recommendation would appear to increase federal spending, in practice it would reduce federal spending as states would have strong incentives to innovate and generate savings with Medicaid reform, something lacking today.

3. Allow proven waivers to be seamlessly incorporated into state plan amendments. The waiver process is often accompanied by uncertainty about whether and when the federal government will approve requested reforms. Because waivers have a limited duration, this uncertainty persists even for reforms that have proven effective and popular. Currently, states are operating under 378 different active waivers and have another 27 waivers pending with the Centers for Medicare and Medicaid Services.[45]

Congress could embrace an accountable, common sense approach to Medicaid oversight by granting states the flexibility to turn previously-approved waivers into permanent state plan amendments once the waivers have been proven effective. Doing so alleviates the stress and uncertainty states now face as their waivers approach scheduled expiration dates. This also ensures patients' care and taxpayer savings do not face interruptions resulting from lengthy renegotiations with CMS. Further, states should be able to incorporate a reform proven effective in other states into their own state plans without enduring the burdensome waiver process and scrutiny the reform already received elsewhere.

This would allow states to avoid months- or years-long delays for waiver approval. Reforms accomplished through state plan amendments can expect approval within 180 days. And rather than needing approval again after just a few years, a state plan amendment becomes a permanent part of a state's Medicaid program unless changed by a future state plan amendment.

4. Provide greater flexibility on mandatory and optional services. Customized benefit packages provide patients with the greatest value and competition among plans has proven effective at reducing costs for taxpayers. In Florida, Medicaid patients can choose from up to 31 different, customized benefit packages.[46] The state allows health plan providers to offer customized benefit packages as long as the benefit packages are actuarially equivalent to the state plan and still provide key benefits at a level sufficient to meet patient needs.[47]

But states and health plan providers are hamstrung by federal rules dictating how much they can customize benefits. Federal rules require coverage for inpatient hospital services, outpatient hospital services, early and periodic screening, diagnostic and treatment services, nursing facility

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[45] Centers for Medicare and Medicaid Services, "Medicaid waivers: Dynamic list," U.S. Department of Health and Human Services (2013), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/dynamic-list/WA-508.xml.

[46] Florida Agency for Health Care Administration, "Florida Medicaid reform: Year 6 annual report," Florida Agency for Health Care Administration (2012), http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/FL_1115_YR_6_Final_Annual_Report_07-01-11_06-30-12.pdf.

[47] Florida Agency for Health Care Administration, "Florida Medicaid reform: Application for 1115 research and demonstration waiver," Florida Agency for Health Care Administration (2005), http://ahca.myflorida.com/medicaid/medicaid_reform/waiver/pdfs/medicaid_reform_waiver_final_101905.pdf.

services, home health services, laboratory and x-ray services, family planning services, nurse midwife services, certified pediatric and family nurse practitioner services, freestanding birth center services, transportation to medical care and tobacco cessation services.[48] States may only choose which additional services to offer and set the scope and range of those services.

With added flexibility from the federal government, states could offer more customized benefit packages to vary these minimum benefits, so long as the benefit packages meet specified actuarial standards. One potential avenue for this customization would be to grant states much more flexibility for benchmark Medicaid coverage.

States currently have the option to design benefit packages for certain populations that vary from traditional Old Medicaid.[49] However, the flexibility provided in designing these benefit packages, known as "benchmark coverage" or "benchmark-equivalent coverage," is limited in nature. The benefit packages must be equivalent to the standard Blue Cross/Blue Shield health plan offered to federal employees, the health plan offered to state employees or the largest commercial, non-Medicaid health maintenance organization plan offered in the state.[50] Benchmark-equivalent coverage must also provide specified mandatory services.[51] Current law also requires states to "wrap around" benchmark coverage with additional benefits not typically covered by private insurance, such as transportation services to and from medical visits.[52] The Affordable Care Act further requires such benchmark-equivalent coverage include all essential health benefits.

Given adequate flexibility, states could restructure their covered benefits to provide truly patient-centered customized benefit packages. And if plans meet a target actuarial value, states should be free to allow plans to be offered that vary covered services and benefits, including those that are federally mandated, as well as the amount, duration and scope of those services. States would evaluate each proposed customized benefit plan in order to ensure plans meet the target actuarial value.

This will create greater competition within the Medicaid marketplace, lowering the cost to taxpayers and improving quality. Patients will be able to prioritize benefits according to their personal needs and circumstances and select the plans that will provide them with the greatest value. For example, a patient may wish to select a plan that does not offer transportation services, but instead select a plan that offers a better dental benefit package. They deserve that choice.

5. Create an off-ramp for Medicaid. Currently, federal restrictions on marketing private insurance plans to individuals transitioning off of Medicaid impose an undue burden on those leaving Medicaid. These restrictions further worsen the gaps in coverage for individuals leaving

[48] Centers for Medicare and Medicaid Services, "Medicaid benefits," U.S. Department of Health and Human Services (2013), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html.
[49] 42 C.F.R. § 440.300 et seq.
[50] 42 C.F.R. § 440.330.
[51] 42 C.F.R. § 440.335.
[52] 42 C.F.R. § 440.390.

Medicaid. As Florida's Reform Pilot has proven, Medicaid patients can and do make informed choices about their health coverage when given access to appropriate information. Denying them such information while they are transitioning off of Medicaid hinders their ability to make educated choices, taking away their power to make meaningful decisions over their health futures.

Other federal rules and regulations restrict states from using Medicaid funding in innovative ways to move individuals off of Medicaid and into private coverage. With greater flexibility in this area, states would be able to take proactive steps to create an off-ramp for Medicaid, helping ensure that Medicaid patients are not trapped in government dependency and a culture of poverty, but rather help them move from poverty into long-term employment and productivity.

Conclusion

Despite Medicaid's fiscal challenges to state budgets and the federal budget, there are proven strategies that are working today for both Medicaid patients and taxpayers. However, the current funding structure, new taxes, a slow federal process, and perverse incentives inherent in Medicaid expansion threaten Medicaid services to the most vulnerable. It doesn't have to be that way. With reasonable flexibility, targeted incentives, streamlined administration, and a smooth off-ramp, the Medicaid safety net can work better today for patients and providers and be sustainable for taxpayers into the future.

Mr. PITTS. We will now begin questioning. I will recognize myself 5 minutes for that purpose.

For the Nation's vulnerable citizens, having Medicaid does not always result in good health care. Studies have shown that while enrollment is growing rapidly, with more than 70 million Americans enrolled in Medicaid at some point in 2012, access to quality care is still a struggle for most. The new health care law proposes the largest expansion of Medicaid in history, an expansion that is clearly built on a framework that is already failing to meet current obligations in helping our most vulnerable citizens.

Mr. Bragdon, in your testimony you note that States should be cautious in opting into Medicaid expansion. At this point, the majority of States are either not expanding or are still undecided. What are some considerations you would raise with States that are still deliberating the decision to expand in 2014?

Mr. BRAGDON. Thank you for the question.

When you look at States that have expanded Medicaid in the past, the two States that have most closely replicated the expansion of the Affordable Care Act are Maine and Arizona. And the realities of those States were much higher per-person cost, much higher per-enrollee cost, and many more people enrolling than originally projected. And what happened was, as that safety net was stretched further and further, those States proposed and did cut services to the most vulnerable. Arizona stopped covering heart and lung transplants. Maine proposed cutting services to folks with brain injury and stopped paying their hospitals altogether, mounting $400 million in unpaid bills dating back over 5 years.

So what happens as States expand is the most vulnerable, who tends to be higher cost, as was mentioned, the services are cut back on those individuals first.

Mr. PITTS. Ms. Owcharenko, would you respond to that question as well?

Ms. OWCHARENKO. Sure. I think the primary caution I would give to the States is you have to take the long view of what the future of Medicaid is going to look like versus just the short view. I think the temptation of the bump in Federal dollars to the States is a tempting offer, but it has a very short-term impact. And I think States need to take the longer view, not only for their own State taxpayers, but for Federal taxpayers who their constituencies are as well. So looking at what are the implications at the Federal level, understanding that our country cannot survive on the spending path that we have today.

Mr. PITTS. Now, in your testimony you mention some of the innovations States are pursuing. From your experience, what are some of the barriers that States face in pursuing new innovative delivery models, such as those outlined in your testimony?

Ms. OWCHARENKO. Well, I think one of the things that has been mentioned by many of the folks here is the lack of flexibility at the Federal level. Too many times the States have to figure out which holes to jump through, how to get things done. Even if we think that they are making progress today under current rules, imagine what States could do if they had greater flexibility to do more innovative projects without having to have the constraint of all the Federal requirements on there. I think that would probably be the best

direction for the States to take and the Federal Government to enable them to.

Mr. PITTS. Each of you have highlighted the value of managed care and increased care coordination in the Medicaid program that moves us away from Medicaid's flawed fee-for-service history, and it improves care and reduces costs. If given one opportunity, what would be an important policy reform to pursue that would allow for States to more easily pursue managed care models for Medicaid? If each of you would respond. Start with you, Ms. Owcharenko.

Ms. OWCHARENKO. I think expanding without having to do so many waivers on the populations that could be included. I would argue that the States know best when they are trying to develop and deliver care to the most vulnerable, which groups they think are best suited for the managed care approach.

I would also note, though, that it is not just good enough to have one managed care plan. What you want is insurers competing against each other. And so making sure that there is competition and giving the patients the choice to choose I think will alleviate concern that there may not be a plan that is best suited for the most vulnerable.

Mr. PITTS. Mr. Weil.

Mr. WEIL. The rapid movement of States in their Medicaid population toward managed care makes it hard for me to see that there is a major Federal barrier to reliance on managed care. The primary area that remains a challenge is integration with the Medicare program. We do have some demonstrations going on right now designed to enable alignment of managed care plans between Medicare and Medicaid. I think we are going to have to see how that evolves. But that, to me, is the population that faces the largest barriers in that movement.

Mr. PITTS. Mr. Bragdon.

Mr. BRAGDON. Thank you. I think there are a few different things. One, looking at the robust competition among private plans. Nobody is suggesting that Medicaid not set the floor of benefits that should be available in those private plans. But as the plans build on top of that, you can provide much more comprehensive care that Old Medicaid does not. For example, Kansas added a dental benefit when they moved to a private plan. GED services so that individuals could ultimately get the best safety net, which is a good-paying job. Florida shows how when you give people choice and choice counseling, which I think is an important component, so that patients understand the differences among those private plans.

I think lastly, there is this debate over mandatory versus voluntary private care. But when you look at how patients vote with their feet, patients appreciate having robust choices of several different private plans. In Kansas, Native Americans are given a choice of whether to choose from one of the three different private plans or opting back into Old Medicaid. Out of 4,000, only 12 stayed in Old Medicaid. Louisiana, 0.3 percent of people voluntarily chose Old Medicaid versus five different private plans.

Mr. PITTS. Thank you.

The chair recognizes the ranking member, Mr. Sarbanes, for 5 minutes for questions.

Mr. SARBANES. Thank you, Mr. Chairman. I want to thank our panelists today.

Mr. Weil, Ms. Owcharenko mentioned challenges to the Medicaid program. And I didn't hear that that necessarily formed an indictment of the program overall, but it just laid out what some of the challenges are. I wanted to get maybe your reaction to those challenges, whether you think the Medicaid program can handle them.

So the first one obviously is the demographic challenge that is coming at us, particularly the baby boomer generation and the implications that has for the Medicaid program, and this notion of competition within the diversity of the pool of beneficiaries that is covered by the Medicaid program. These are realities we are going to have to deal with. My sense is an expanded Medicaid program that we are trying to make better every day is going to be best equipped to handle that challenge.

She spoke of structural challenges—for example, relating to payment rates. Did acknowledge that in 2013 and 2014 there is an attempt made to achieve 100 percent parity with Medicare rates for primary care. That is a good step in the right direction. And then spoke of the fiscal challenges ahead of us, with entitlement programs or, as I often refer to them, earned benefit programs in some instances.

But your testimony suggested that in some ways Medicaid is on the cutting edge with respect to innovations that not only can improve care, particularly care that one might put under the heading of sort of public health. When you look at children, developmental screening, where what the Medicaid program does is really cutting edge, ahead of both the commercial arena and potentially even Medicare there. The dental care for children and patient-centered medical homes. Among many examples you gave, these are things—particularly the last one I mentioned—that can improve efficiencies and save costs over the long run. And it is really because of ACA that we are going to see some opportunities for that.

So can you address these challenges, the demographic, structural, fiscal, and other challenges you see, and why an expanded Medicaid program in some ways may be best equipped to handle them?

Mr. WEIL. Thank you, Mr. Sarbanes, for the question.

The demographic challenges are real. They affect Medicare as well as Medicaid. We can't ignore the reality that we are aging and they will increase the average cost per person.

But I think against that backdrop it is worth noting that despite aging of the population, the Medicaid nursing home census has stayed flat despite the aging of the population, that our use of home- and community-based services grows, and some leading States have really shown us how to not just prevent people from going into nursing homes in the first place but help them come home even after they have been resident there for some time. Washington State is a leader in that regard.

With respect to your question about expansion, I think we need to be careful about what I heard the repeated use of the term able-bodied adults, as if somehow they don't need health insurance. If they are not sick, then the good news is they won't cost us any money. So we shouldn't be so worried about providing them with

coverage. But everyone gets sick, sometimes more than others, or they may have chronic conditions that are untreated, that getting them early care will actually reduce the overall cost. And we know there is growing prevalence of chronic conditions, particularly among the target populations in the Medicaid expansion.

The issue here is, are we going to move this population into a system where there is someone responsible for managing their care, a State and Federal Government responsible for paying, and usually a private plan—and I should note, most States offer their Medicaid enrollees a choice of plans—a private plan that is interested in maintaining health or do we just leave them the alternative? The only alternative I am aware of is that they are uninsured and no one is accountable for improving results.

And similarly, I will readily admit that Medicaid payment rates are below commercial and in some instances below Medicare rates. But again, I think we have to ask, compared to what? These are people who would otherwise be uninsured. There would be no payment source for them. There are mission-driven providers and other providers that have a broad cross-section of patients that understand that they are going to subsidize care for some in order to serve others. And Medicaid helps alleviate the burden, although it does not completely eliminate it.

So these are challenges. But my experience is that States observe them, look ahead, and are doing what they can to tackle them within the design of the current program.

Mr. SARBANES. Thank you very much. I yield back.

Mr. PITTS. The chair thanks the gentleman.

Now recognize the vice chairman, Dr. Burgess, for 5 minutes of questioning.

Mr. BURGESS. Thank the chairman for the recognition.

Ms. Owcharenko, let me ask you, we have heard it mentioned several times in the opening statements and I believe in your testimony about low provider rates and how that affects access for Medicaid patients. So low provider reimbursement rates. Medicaid is a shared Federal and State responsibility. So how can the Federal Government ensure provider rates are set at levels that will encourage participation?

Ms. OWCHARENKO. Well, I think one of the points is that you have to contrast it with the fiscal challenges. So if you have provider payment issues, you are not paying providers enough, then the easy solution is to say, well, just pay them more. Well, to pay them more you have to pay for that, and so someone is going to have to pay for that. The States have decided in many instances they are not willing to spend the money to the Medicare levels; otherwise, they wouldn't have had the Federal Government come in for the temporary boost.

The challenge is, what happens when that boost is gone? Can the Federal Government continue to provide that type of a level of reimbursement? I think that is the whole problem we have with Medicaid in the long term, is it sustainable from a fiscal standpoint?

Mr. BURGESS. Well, let me just ask you, for that 2-year interval, who is responsible for paying those increased rates?

Ms. OWCHARENKO. Well, the Federal Government. Well the Federal taxpayers are paying that.

Mr. BURGESS. Then past 2015?

Ms. OWCHARENKO. It will go back to the States. And as the MACPAC study said, many States are already saying that it is doubtful that they will be able to keep and sustain that level. So the challenge will be, the States will be back here in Washington saying, we need more Federal dollars, and we don't want them temporary, we want them permanent. Well, then, the Federal Government is going to have to find the money, if they are going to go down that road. And I just would argue that the Federal Government doesn't have the money today to be continuing that type of spending.

Mr. BURGESS. We have actually seen that movie before. The stimulus, in February of 2009, provided an 18-month bump-up in Medicaid reimbursement rates, as it was about to run out in August of 2010. As I recall, we had to have an emergency meeting of Congress in the middle of the August recess—one of the few times that has happened, except for war and pestilence—and the purpose of that was to pass a supplementary stimulus bill to augment those Medicaid rates. For the record, I voted against it both times.

Let me just ask you a question, because we are looking at the—you have States that have agreed with Medicaid expansion and some that have not. Now, the Supreme Court in their wisdom said that you could not make acceptance of the standard Medicaid, regular Medicaid contingent upon the acceptance of the expansion. So States actually have some leeway there. The deadlines for the exchanges, since this expansion of Medicaid was not set in Federal statute but rather by a court directive, there are no dates, there are no drop dead dates for the States. So actually, wouldn't a State be well advised to see what happens in a few other States before they jump into this?

Ms. OWCHARENKO. I think with the complexity that we see the healthcare law facing, I think it would be wise for States to think again for the long term and see how this plays out. I think this will be an annual debate I think moving forward as well.

Mr. BURGESS. But at this present time, there is no penalty for a State that says, not now.

Ms. OWCHARENKO. That is correct. That is correct.

Mr. BURGESS. And they can always revisit it in subsequent legislative sessions in the future.

Ms. OWCHARENKO. That is correct.

Mr. BURGESS. When you get back to getting the providers to get back into the system, I can remember in Texas in the early 1990s, the State said, look, we will cover your first $100,000 in medical liability claims for Medicaid patients if you agree to see a certain number. That program did not last very long. I presume it was a cost-related factor. But it seems that something along those lines, to encourage providers to come back into the system, would make a great deal of sense.

Is there flexibility built into this Medicaid expansion that would allow States to do that?

Ms. OWCHARENKO. I am not familiar with any at this time. But the other panelists may know more than I do on that.

Mr. BURGESS. Mr. Weil, let me ask you a question, because you mentioned something about the Center for Medicare & Medicaid

Innovation and the use of—what did you describe it as, multipayer systems? Could you provide us a reference for that? I would be interested in what the data was that CMMI used to make that determination, how much money was forwarded in those grants. Do you have that information available? If not today, could you make it available to us?

Mr. WEIL. Yes, Mr. Burgess. I would be happy to. That is public information. We are quite early in these cooperative agreements. But the States that were awarded them, what they intend to do with the funds, that is all public. It is available from CMS, and I am happy to supply it to you.

Mr. BURGESS. All right. I would appreciate you making that available. My experience with CMMI has not been that great. It seems to be a bureaucracy that not even a bureaucrat could love. But I would be interested in what you base those statements on.

Thanks, Mr. Chairman. I will yield back.

Mr. PITTS. Chair thanks the gentleman.

Now recognize the distinguished ranking member emeritus, Mr. Dingell, 5 minutes of questions.

Mr. DINGELL. Mr. Chairman, I thank you for your courtesy, and I commend you for holding this important hearing today.

Medicaid is a critical program. It provides health insurance to the most vulnerable in our society. Many States, including my own State of Michigan, are currently deciding whether to expand their Medicaid programs under the Affordable Care Act. I believe expanding the program was the right thing to do because it is going to expand health care to millions of Americans who desperately need it.

These questions are for Mr. Weil of the National Academy for State Health Policy.

Mr. Weil, in your testimony you note that Medicaid is a source of insurance coverage for one out of three children. Is that correct? Yes or no?

Mr. WEIL. Yes, sir.

Mr. DINGELL. Now, Mr. Weil, children and their parents account for 75 percent of Medicaid enrollees. Is that correct? Yes or no?

Mr. WEIL. Yes, that is correct.

Mr. DINGELL. And this population accounts for only 34 percent of the spending in the program. Is that correct? Yes or no?

Mr. WEIL. Yes.

Mr. DINGELL. One area where Medicaid has been very innovative is the area of developmental screening for children which helps promote early detection and prevention of healthcare problems? Mr. Weil, how many States require Medicaid providers to perform developmental screenings on children as a part of routine exams? I believe the number is 14. Is that right?

Mr. WEIL. That sounds right.

Mr. DINGELL. They are not, however, required to require this kind of work. Is that correct?

Mr. WEIL. That is right.

Mr. DINGELL. Now, Mr. Weil, recently we have seen the national percentage of children receiving developmental screening rise from 19.5 percent in 2007 to 30.8 percent in 2012. Is that correct?

Mr. WEIL. Yes, sir.

Mr. DINGELL. This is a great improvement, and I believe Medicaid's innovation in this area has helped increase the number of children that undergo developmental screening tests. Mr. Weil, is it correct that a child with public health insurance is now more likely to receive a developmental screening than a child with private insurance? Yes or no?

Mr. WEIL. Yes, it is.

Mr. DINGELL. Now, Mr. Weil, oral health is another area where State Medicare programs are successfully implementing innovative programs and are seeing positive results. Isn't that so?

Mr. WEIL. Yes, it is.

Mr. DINGELL. Now, Mr. Weil, do you believe that the reforms in North Carolina and Washington, with which I think you are familiar, which you described in your testimony, have led to positive health outcomes and are models for other States to follow. Is that right or wrong?

Mr. WEIL. Yes, it is.

Mr. DINGELL. Now finally, a recent study in the New England Journal of Medicine studied the impact that expanding Medicaid has on mortality rates. So, Mr. Weil, do you agree with the conclusion of this study that expanding Medicaid will lead to lower rates within the States that do it? Yes or no?

Mr. WEIL. I believe the strongest evidence says that expanding Medicaid will reduce mortality. That is correct.

Mr. DINGELL. I very much thank you for this.

I believe Medicaid brings real health benefits to our vulnerable populations. The States are currently coming up with new, innovative strategies to improve access to care.

As States across the Nation, including my own State of Michigan, are debating whether to expand Medicare or not, I hope they will look at this evidence as how the program is working to improve health outcomes for millions of Americans. States should also consider the financial benefits for expanding Medicaid as well. Michigan alone could save $1 billion over the next 10 years if they chose to expand Medicaid, which I hope they will do.

I hope this committee will continue to examine this issue in a bipartisan manner.

Mr. Weil, you have been most helpful to us.

Thank you, Mr. Chairman. I yield back 1 minute and 15 seconds.

Mr. PITTS. The chair thanks the gentleman. I now recognize the gentleman from Georgia, Dr. Gingrey, for 5 minutes for questions.

Mr. GINGREY. Mr. Chairman, thank you.

Let me—I want to address the first question to Ms. Owcharenko. Much has been said that the Medicaid waiver program offers States all the flexibility that they need to improve and reform their programs, the existing waiver program.

As you know, this administration is a strong supporter of the Medicaid population expansion, you said up to 138 percent of the Federal poverty level. May there be an opportunity for the administration to intentionally withhold waiver determinations if the State does not get with the program and expand?

Ms. OWCHARENKO. I can't speculate, but we do know the waiver process is long and cumbersome, and you don't know when, there is no time limit on how long a process may take or the complexity

of the waiver. But we also need to recognize, too, that the waiver is dictated by the statute. There are only certain things that can be waived and so to the point that you want to do something above and beyond what the statute allows you to, that still is a limitation, but I can't speculate.

Mr. GINGREY. Well, Mr. Chairman, we have seen this administration continually use almost coercive methods to aid implementation of the law. Allowing Medicaid waivers as the only process for States to innovate seems to offer the administration a situation ripe for abuse. This is why we need to repeal the Medicaid and CHIP maintenance of effort provisions and give States a chance to truly innovate.

Continuing along that line, the maintenance of effort provisions in Obamacare have not only been costly, but they have been a barrier to reforms. That is why I introduced H.R. 1472, the State Flexibility Act to repeal PPACA Medicaid and CHIP provisions in the President's health care law, repeal the maintenance of effort.

In these difficult fiscal times, States often must make cuts to other non-mandated programs, such as education, because they don't have the flexibility to improve their existing Medicaid programs. In other words, get rid of people that are on the rolls that shouldn't be there that maybe 2 years ago, 3 years ago, prior to PPACA, these people were eligible but now they are making $75,000 a year, and they are frozen on the program.

Would you please explain to the panel how these provisions increase costs to both the States and the Federal Government and actually hamper patient outcomes?

Ms. OWCHARENKO. I would say that the maintenance of effort freeze really does take a tool out of the toolbox that States have to work within their budgets within their means and within their budgets to provide the care to who they feel are the most vulnerable and the most needy. Again, getting back to the flexibility for the States, I think the closer the policymakers are to what is going on on the ground at the State level, the better are suited in deciding who should get the care, where the adaptation should be, where we can scale back maybe, or where policy should be increased.

Mr. GINGREY. Well, I'm just thinking that if they didn't have that maintenance of effort provision and they were able to kind of clean up the rolls, if you will, then maybe some of these States would be willing to expand, because they wouldn't be throwing money at people that really don't need it. Mr. Bragdon, would you care to comment on that as well?

Mr. BRAGDON. Thank you. I think that you are touching on an important point that when you look at how States can customize their Medicaid programs, that you need different solutions for different populations, and you also need a very dynamic toolkit, if you will.

In Florida, for example, the average single mother who is on welfare, or on TANF and receiving Medicaid is on the program for 5 months. And so for those individuals, it is also about creating some sort of off-ramp, because what happens now is you are on Medicaid, you may be in a private plan you like, but there is no ability to keep that private plan once you go off the program, there is no ability to even become aware of what is available to people——

Dr. GINGREY. I'm going to interrupt you because I just have 30 seconds left. I want to make this comment. And I thought about this of course 3 ½ years ago right here when we were in the minority on the side when this bill was being developed, and this Medicaid expansion, up to 138 percent of the Federal poverty level, where would those people get their care if they were not eligible for Medicaid? They would get it on the exchanges and the provision that goes to them would be all Federal dollars. They wouldn't be State dollars. So it is really a game of moving the hat around to see where the pea is.

You clearly, that was a setup so that there would be less Federal costs and more burden on the backs of the States. And I yield back.

Mr. PITTS. The chair thanks the gentleman.

The chair now recognizes the gentlelady from Florida, Ms. Castor.

Ms. CASTOR. Thank you very much, Mr. Chairman.

Thank you to the panel.

This is a very important topic, and as Mr. Weil testified, there are so many exciting innovations going on all across the country when it comes to Medicaid that is the lifeline for families and seniors and children and disabled.

I have wanted to, I think it is very important that we share and understand what is happening in these innovations. We do this on a regular basis for those that are interested in the children's health care caucus that I co-chair with Republican Congressman Dave Reichert from Washington State where we educate staffers across Capitol Hill, other policymakers, Members, and we have another of our Medicaid matters for kids sessions this Friday here in the Rayburn building at 12 o'clock, and I would like to thank First Focus Campaign For Children, all the children's hospitals across the country, the pediatricians, the Kaiser Family Foundation for helping to organize these very important Medicaid educational sessions. The one on Friday is called "Unlocking Ideas to Improve Care For Kids on Medicaid."

One of the most exciting innovations I know of in Florida in my home town at St. Joseph's Hospital is their complex, their chronic complex clinic for children. It has been running for 12 years now. It provides continuous comprehensive and coordinated care for the most medically needed children in our community. The clinic was organized after years and years of watching children cycle through the emergency room without a real focus on their ongoing health care needs. The hospitals desperately wanted someone to provide them with coordinated care. So the clinic came together. It now serves over 1,000 children in the Tampa Bay area with a great team of pediatricians, pediatric nutritionists, nurses, social workers and many others. The families in my area love this clinic. And we also appreciate the fact that it saves $6,000 per patient per year in hospital costs alone and some national studies say that we are saving closer to 10,000 a year. That is one of the innovations that I am excited about.

Mr. Weil, name another one where you, where things are going right under Medicaid, this important Federal/State partnership.

Mr. WEIL. Well, I think some of the most exciting work is in the area of patients in medical homes and health homes where what

we are trying to do is take a health care system, not just in Medicaid but in the system at large that primarily sends its resources to the most expensive settings for care for hospitals, for institutional care and build out, as you described in the scenario you described, build out an infrastructure of the kind of care people need at a better touch, it is closer to the community, it is less expensive, it is less episodic, it is more continuous, and also, and I think some of the best innovations going on now are about bringing in mental health into how we think about delivering health care. We have traditionally had very strong lines and barriers between these systems, different funding streams, different programs, and we are understanding that people with untreated mental health conditions cost more in physical health, and that the relationship between the two requires a different model of care. We are seeing it in oral health. I including included a few examples in my written testimony.

And what is great about these kinds of innovations is that Medicaid is a part, sometimes it is a leader, sometimes it is a follower, but most providers of services within Medicaid also provide services to privately covered folks, and if they are, if it is not pediatric care, they are usually in Medicare as well.

So the interesting exciting innovation, the most interesting exciting, from my perspective, is when Medicaid is part of a broader conversation across public and private payers and providers, physicians and hospitals and others to fundamentally rethink how people get care, and then pays in a way that supports that as opposed to just writing checks for services that people need.

Ms. CASTOR. I think you are right. I think you are right.

And Mr. Bragdon, I know you did not mean to mislead this committee by heralding the great success of Florida's Medicaid privatization. The statewide waiver was just approved a couple of weeks ago. So be careful when you testifying in front of Congress. And then the pilot program of Medicaid privatization was known as a real disaster. The State's own study condemned the results. We had patients unable to gain access. We had providers, private providers leave the State.

So be careful when you testify before Congress and saying this is a great success when the evidence and everyone across the board has really condemned what has happened. We are more hopeful with the new waiver and privatization, it is like night and day. There are broad new conditions for consumer protections. Providers, if they back out and leave, are going to be penalized, their medical loss ratios.

So those are some of the innovations that can happen with that important Federal/State partnership. But you have got to, you really have to do your homework on what has happened in the past and what is actually happening moving forward. Thank you.

Mr. PITTS. The gentlelady's time has expired. The chair recognizes gentleman from Louisiana, Dr. Cassidy 5 minutes for questions.

Mr. CASSIDY. Thank you, Mr. Chairman. Mr. Weil, I am a doctor who takes care of Medicaid patients in a public hospital clinic, so I am very familiar that Medicaid can actually have a beneficial ef-

fect. But I think there are some things kind of in the interest of Ms. Castor's kind of fact check sort of thing.

Let's first talk about the paper that Mr. Dingell referenced that showed an all-cause decreased mortality after Medicaid expansion. Now, I happened to have read that article and I happened to know and I looked it up just to confirm. In Maine, actually mortality increased after Medicaid expansion. The authors point out only in New York was there a statistically significant effect of decreased mortality, and that overwhelmed the increased mortality in Maine and the no significant effect in Arizona.

So would you disagree with that table which I am looking straight at or would you acknowledge that, indeed, it is only one-State specific and indeed, if we were to look at Maine, we would actually see an increase in mortality after Medicaid expansion?

Mr. WEIL. I will happily defer to you looking at the table and say that as you know as a clinician, you never want to take your conclusions too far based on one or two studies and I think we are right now in an environment where people are looking at one or two studies and using it to caricature a program. So I appreciate your clarification very much.

Mr. CASSIDY. Secondly I also point out and you were very careful in your testimony to say that Medicaid prevents people from having financial duress, but you did not make the claim that it improves health. And again, as you and I both know the National Bureau of Economic Research found in their Oregon study that when, and I am quoting from their conclusions, this randomized controlled study showed that Medicaid coverage had generated no significant improvements in measured physical health outcomes in the first 2 years, but it did reduce financial strain.

So it also makes it clear that the best study from NBER has shown that Medicaid expansion did not improve health outcomes.

And lastly I will say that in your—by the way, I enjoyed everybody's testimony and I don't mean to challenge, I am just trying to point this out, you seem to suggest in your testimony that the choice is dichotomous, either somebody is uninsured or they are on Medicaid. But then I will quote another National Bureau of Economic Research study, again, by Mr. Gruber, who is a big backer of Obamacare, who points out that 60 percent of the children that go on to a public insurance program actually formally had private insurance but the expansion of the public insurance crowded out, if you will, the private insurance so it is not the employer or the family paying the bill, it is now a taxpayer paying the bill. And that is 60 percent.

Any comments upon that because again, it is not—you know where I am going with that.

Mr. WEIL. Well, I do have to begin by commenting on your characterization of the first study. First of all, there were, as you know, demonstrated positive effects on depression, so the physical health word is important. But I don't think it shows that it did not improve outcomes. I think it didn't show that it improves outcomes. And I think those are actually quite different. We don't——

Mr. CASSIDY. But if questions take the no hypothesis we really cannot claim a benefit unless the benefit was shown.

Mr. WEIL. I completely agree with you. We cannot claim a benefit unless the benefit is shown. That does not equate with the absence of benefit, it simply means we were unable to show a benefit. And since you are being very careful, I am going to ask that we be equally careful in that regard.

The literature on crowd-out which used to be a very hotly debated topic and has faded from view for some time has great complexity about what you count as the numerator and the denominator. We know that low and moderate income people and families, their income fluctuates and they do gain different sources of coverage, although the prevalence of private coverage——

Mr. CASSIDY. I only have a minute left.

Mr. WEIL. I am sorry. My sense would just be, I don't think that we can state on the basis of the Gruber study that 60 percent of those children would still have private coverage if they did not public coverage.

Mr. CASSIDY. Maybe. I will say they had 400,000 observations, and Gruber obviously is, one, respected and, two, a big backer of the Obamacare, so it is not like he is trying to find something to trash himself.

Lastly, is there a philosophical difference if a State is going to manage care and they are going to capitate payment to the insurance plan, is there any difference in facts that if the Federal Government gives only a set amount of money to the State, which, in turn, gives a set amount of money to the insurance plan? Is there any kind of difference in that?

Mr. WEIL. Well, yes, a plan organizes and finances the delivery of care. A State organizes the policy environment for that finance and delivery, so they are akin, but I think they have different effects.

Mr. CASSIDY. But if you give $100 to the State to care for somebody and the State gives $90 to the insurance plan, that really is the same mechanism, the capitated payment in each case.

Mr. WEIL. If 100 percent of the cost were through capitation, and it was just who wrote the bill, then I would agree it is the same, but that is not how I see the program.

Mr. CASSIDY. OK, that may be an issue of perception. I yield back.

Mr. PITTS. Mr. Bragdon, did you want to respond to Ms. Castor's remarks regarding Florida reforms? I apologize that she had to leave, but I wanted to give you an opportunity to respond quickly. Please.

Mr. BRAGDON. Thank you, Mr. Chairman, I appreciate the opportunity.

In my testimony, I referred to the Florida reform pilot. The facts are very clear: The Florida reform pilot outperformed on health outcomes in 64 percent of the cases. It had higher levels of patient satisfaction in 82 percent of the cases. But perhaps the best validation of how this approach of patient-centered pro-patient/pro-taxpayer is working is the fact that the Obama administration approved the waiver.

This is a proven bipartisan approach that saves money, improves health and produces more satisfied patients. And would be happy

to provide further information to the Congresswoman so she can understand that.

Mr. PITTS. The chair thanks the gentleman. The chair now recognizes the gentlelady from Virgin Islands, Dr. Christensen, for 5 minutes for questions.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman, and thank you for the hearing, and welcome to our panelists.

And Mr. Weil, my first question was really about Medicaid flexibility, but I think your testimony and the answers that you have given really have demonstrated that flexibility and innovation are not only possible, but they are happening in different States across the country and improving access and actually in some of the cases you cited, improving outcomes as well. Improved outcomes is what we are all looking to achieve here.

I am sure that all of you are familiar with the 2002 IOM Report on Unequal Treatment, a report that demonstrated bias and discrimination in health care, in the health care of racial and ethnic minorities, still in other studies, more recent studies since that have demonstrated the same as it relates to cardiac care and other medical conditions.

We know that racial and ethnic minorities make up at least 58 percent of non-elderly Medicaid enrollees. And in addition to that, the prior low reimbursement rates, limited accesses to providers, and even when there were providers, some of the needed ancillary services were not available in the neighborhood because of how Medicaid was paid for before the Affordable Care Act.

So Mr. Weil, don't you think these factors have some impact and import on whether, even with Medicaid being available and access to health care being available, don't those factors parallel? We haven't even talked about the socio and economic determinants of health that are not changing in those communities.

Mr. WEIL. Well, I appreciate the question and the observation. I am struck by how frequently I hear people repeat the phrase that Medicaid is a lousy, broken program because people on it, and then they fill in the blank. The people on it are poorer and sicker and disproportionately nonwhite, and as you indicated there is a strong evidence based in all of those areas that health outcomes are worse regardless of source of coverage, and very rarely do people make an effort to actually control for it, because it is impossible to control——

Mrs. CHRISTENSEN. Even regardless of income level and education level.

Mr. WEIL. So we know, for example, that lower income Americans are less likely to use health care services whether they have private or public coverage because they are less comfortable—on average, they are less comfortable with the system, less able to navigate it, and providers seeking payment are less likely to locate in the places where they live. To indict the Medicaid program for the outcome of that seems to me a bit odd.

Mrs. CHRISTENSEN. I agree and thank you because when those inequities are addressed then the socioeconomic determinants of health when they are addressed in poor and racial and ethnic minority communities and rural communities, and some of the reforms that you have cited in the different States are more widely

adopted, I think we will see those changes. And we are seeing changes where those things are happening. They are really making a difference in improved care for vulnerable patients for whom Medicaid has been their lifeline.

The Affordable Care Act recognizes that we needed to begin to make Medicaid a stronger safety net. The law, along with State changes, is already beginning to make a difference. The Republican-recommended reforms really are not designed, as I see it, and I am a practice, I was a practicing family physician to help the vulnerable. I think they run the risk of reducing access to care and leaving some of our most vulnerable out of the health care system entirely.

Let me see if I can fit in one other question.

The Affordable Care Act includes a provision which will provide additional payment to certain Medicaid providers for primary care services. What impact on access to primary care do you believe that this policy will have? And what other steps can we take to improve access to these important services for our most vulnerable? Dr. Weil.

Mr. WEIL. Well, higher payment is certainly a positive, although its temporary nature I think is going to limit the behavioral response on the part of physicians. It is unlikely they are going to fundamentally change where they practice or how they practice for an incentive that they know will last a short period. I think it is important to think of that as a step, as an imperfect step in broader efforts to reorient health care system spending toward primary care and it, in and of itself, is not going to achieve fundamental——

Mrs. CHRISTENSEN. It is 2 years probably because we had to reduce the cost of the bill, and we had to reduce the cost of the bill because we could not score the prevention, the savings from prevention which is something we still need to do. Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentlelady and now recognizes the gentlelady from North Carolina, Mrs. Ellmers for 5 minutes for questions.

Mrs. ELLMERS. Thank you, Mr. Chairman, and thank you to our panelists today. I do want to talk a little bit about the North Carolina programs that are moving forward. I am very proud of the work that they are doing in North Carolina. Over, it has grown 90 percent over the last decade from less than 8 billion annually just a decade ago to more than 14 billion annually as of 2012. North Carolina spends more per person on Medicaid than any of its Southern State neighbors. Recognizing North Carolina's Medicaid failures, Governor McCrory has proposed reforms outlining the State's partnership for a healthy North Carolina. And I commend him for his work, and also, North Carolina Health and Human Services chairwoman, Dr. Aldona Wos, for the work that she has done, and I echo the words of Representative Bert Jones in North Carolina calling it a win-win-win situation because it benefits the patients, it benefits the health care providers, and the taxpayers of our State.

With that, I do want to expand a little bit on the Florida issue, because North Carolina is looking at Florida.

And I do have a question, Mr. Bragdon, for you in relation to some of the discussion that has already gone on. Is it not true that Florida's Medicaid reform demonstration was approved 8 years ago, but only last month did the State receive final approval to go forward with the State reforms? Is that part of the situation that we are talking about?

Mr. BRAGDON. Thank you for the question, Congresswoman.

Florida started a reform pilot in five counties, it covered 300,000 individuals, moms and kids as well as those who are on SSI. And then 2 years ago, the legislature voted and the Governor submitted a waiver to expand that reform pilot to all 67 counties.

Mrs. ELLMERS. So it was expansion?

Mr. BRAGDON. Correct.

Mrs. ELLMERS. Great. So basically obviously we are talking about tough times here, scarce resources, drastically growing enrollment levels. States need to know that they can move forward with reforms, and I know that is part of the discussion that we have been having today.

Unfortunately, they are currently forced to live under the "maybe" or wait-and-see approval Federal agency process that takes years to find out whether or not their demonstration projects can be approved.

From your perspective, Mr. Bragdon, what can be done to improve the Medicaid reform review process by CMS? I am sure that is kind of a broad answer, but if you can give a couple of pointers.

Mr. BRAGDON. Thank you for the question. I think first and foremost, States need predictability. You have in the State plan amendment, which is an administrative filing, you have predictability, there are set time frames, if the Federal Government does not act, it is deemed approved. What happens with a waiver is there is no time limit and therefore CMS can drag its feet. In the case of Kansas, CMS approved the waiver 2 days before implementation began.

So what we are seeing is States are playing a game of chicken with the Federal Government moving forward with implementation with the hope that CMS will act at the last minute, otherwise there will be all this wasted effort.

Mrs. ELLMERS. Ms. Owcharenko, I have been practicing your name. Do you want to expand on that at all? Is there anything that you would like to add to that?

Ms. OWCHARENKO. I think that Tarren made a great point about predictability, and I think that this is one of the things that does have bipartisan or nonpartisan issue which is, how can you improve the innovations that are happening in the State faster so that you get more results so that people can study the results to say does this work? Does this not work? And I think that that is one thing I think that people can come together to look at is how do you speed up the process, and allow a lot more innovation at the State level without having the barriers.

Mrs. ELLMERS. Keeping that in mind, right now with Medicaid enrollment at over 70 million, one in four Americans expected to become a Medicaid beneficiary as a result of the ACA, do you believe there are measures in place to ensure proper eligib—after a

week being back in North Carolina I can't speak today—eligibility verification?

Ms. OWCHARENKO. I think that it is actually even before the Affordable Care Act, the trend has been going in the opposite direction with presumptive eligibility, express lane eligibility, those things kind of move in the opposite direction. I think with the massive complexity of this health care law, I think it is important that there are some stronger eligibility processes in place, not only for Medicaid, but on the exchange side as well.

Mrs. ELLMERS. Thank you so much. Mr. Bragdon, I have about one second. Is there anything you would like to add?

Mr. BRAGDON. Ditto.

Mrs. ELLMERS. Thank you, and I yield back the remainder of my time.

Mr. PITTS. The chair thanks the gentlelady and now recognizes the gentleman from Florida, Mr. Bilirakis.

Mr. BILIRAKIS. Mr. Chairman, I thank you for holding this hearing, and I thank the panel for the testimony.

Mr. Bragdon, under the current law the system seems to be rigged to maintain the status quo in my opinion. If a State tries to reform the system to increase outcomes and reduce costs, they typically don't see most of the savings. How can we transform the system to incentivize States and allow them a greater share of the savings?

Mr. BRAGDON. Thank you for the question, Congressman.

I think that this is really a key factor that is holding States back from innovating. States get to keep only about 40 cents of every dollar that they save, or in the case of expansion, 10 cents out of every dollar that they save. What I think would be a better approach to promote innovation would be to have shared savings. One of the things that private Medicaid plans do is they share the savings that coordinated care contributes with providers, so providers have an incentive to save money as well as the plan.

It should be the same with the Federal Government to States. Why not allow the States to keep one out of every three, or one out of every two Federal dollars that they save through innovation?

Mr. BILIRAKIS. Very good. For the panel, what reforms are needed to help beneficiaries transition off Medicaid and on to private insurance? What are the challenges that beneficiaries face? For the panel.

Ms. OWCHARENKO. I would say, first of all, it is prioritizing the population that not everyone on Medicaid is treated the same, and I think that is for a benefit for the beneficiary. The higher up the income scale, the more access you would likely have to private health insurance and that should be encouraged. The same rules that apply at the higher income should not apply at the lower income and vice versa.

Mr. WEIL. I would agree that Medicaid's reliance on private plans makes that transition easier when it occurs, and that States are currently making significant efforts to try to ensure smooth transitions between Medicaid and the exchange. Unfortunately, the biggest barrier to transitioning smoothly from Medicaid into private coverage is that the jobs most people move into when they

move off of Medicaid don't offer health insurance. And so in the absence of that, there is nothing to transition to.

Mr. BRAGDON. I would agree with both responses. I think that you, it is very important to look at for individuals who are on Medicaid, many of them are on Medicaid for a short amount of time, and yet those private plans are prohibited from marketing to them or reaching out to them and just making them aware of here are other options that are available.

And States need to be more creative to create transition products that aren't quite Medicaid private plans but aren't quite private insurance to give people some protection to not only catastrophic coverage, but also preventive services.

Mr. BILIRAKIS. Is it a good idea to provide diversity of plan options to consumers?

Mr. BRAGDON. Thank you. Yes. And I think that the most strong evidence of that is consumers voting with their feet. When you give them a diverse group of plans with meaningful differences, 70 to 80 percent voluntarily pick a plan different than the one they were defaulted into.

Mr. BILIRAKIS. Mr. Weil?

Mr. WEIL. I certainly see advantages to plan choice. It think there are two constraints I would put in that comment. One is that in less populous areas of the country, plan choice doesn't really mean anything because the real challenge is finding providers and having different administrative structures over them doesn't really provide any value.

And the second constraint is that unfettered choice or unstructured choices can be very hostile, actually, to consumers. The private industry knows very well how to structure choices in ways that help people make choices and not bewilder them. But in general, certainly choice is a key component of the drive to quality.

Mr. BILIRAKIS. Ms. Owcharenko.

Ms. OWCHARENKO. I would agree with the panelists and just say, though, that a slight difference a choice of the same product across without any differentiation is kind of choice with no choice, you are not really choosing anything different. So I do think there needs to be some sort of diversification or ability for insurers to offer different types of plans with additional benefits, et cetera, in order to really have what choices.

Mr. BILIRAKIS. Thank you. One last question if I may, Mr. Chairman. Mr. Bragdon and Ms. Owcharenko, the administration seems focused on expanding Medicaid as you know.

How many people are Medicaid eligible and are not enrolled? Shouldn't we focus on getting care to those groups before we focus on expanding Medicaid?

Also, this expansion of patients will increase the patient load on the Medicaid system. Has there been an influx in doctors taking Medicaid? I don't think so. What will this patient surge do to the system? And we will start with Mr. Bragdon, please.

Mr. BRAGDON. I think there are—absolutely there are real challenges to access for individuals. A card is not access. And we need to look at can you actually provide access to care?

Ms. OWCHARENKO. I would just point out that with the question of there are many out there, knowing children, many children that

are eligible but not enrolled in the program, raises the question of what is it that keeps those children out? Is it that they—it is obvious they are eligible. They would qualify. The question is do their parents see that there is value in getting the Medicaid program. As Tarren has pointed out having a card may not be the type of care that best suits them.

Mr. BILIRAKIS. Thank you very much. I yield back.

Mr. PITTS. The chair thanks the gentleman. The chair now recognizes the gentleman from Virginia, Mr. Griffith, for 5 minutes.

Mr. GRIFFITH. Thank you, Mr. Chairman. I appreciate it greatly. Mr. Bragdon, I was looking at your written testimony, and on pages 7 and 8, you go through a process—you may want to refer to it, although you probably know it like the back of your hand—where some of the Medicaid programs that rely on some private programs are going to be hit with the tax inside of Obamacare. Could you explain that to us more fully than just a one- or two-paragraph response might give to the American people?

Mr. BRAGDON. Sure. One of the new funding mechanisms for Affordable Care Act is a new tax on private plans which falls on those private Medicaid plans as well. And so you have this perverse dynamic where the Federal Government is, on one hand, taxing itself and then at the same time, taxing States to raise revenue.

And what is going to happen is States either need to come up with the money or they have to cut services for individuals to pay the tax.

Mr. GRIFFITH. Explain how that works if you can, because I was not here when the bill was passed and I have always been under the impression this was on the wealthier people and on plans that were private plans. Is this because some States have, or work with private-type plans to provide the coverage for their citizens?

Mr. BRAGDON. This is not the tax on Cadillac plans. This is a different tax that is essentially a premium tax for private health plans, but those private plans within Medicaid are included within that tax, and that tax over the next decade is going to raise costs from 37 to $42 million for those private Medicaid plans only.

Mr. GRIFFITH. And the number in your report said something like one-fifth of all the money raised by this new tax included in the Obamacare plan is actually a tax that we paid by Medicaid?

Mr. BRAGDON. Correct.

Mr. GRIFFITH. OK. I appreciate that.

Virginia is looking at a lot of reforms and things before they do the expansion. They set up a special committee, et cetera. And amongst those, I am going to go to a specific question instead of just reciting again the different things that Virginia is looking for, although I think those are good, but one of them is value-based purchasing, and I kind of like that idea that they are looking at. And I think we need to do this in an efficient way that it saves money and provides a greater flexibility to our States. Now obviously, there has to be a balance because you don't want to put a co-pay into that value pricing that keeps people from using services that they may need. So I would ask all of you, from your experience, where have States been able to use that successfully and where has it been not successful?

Mr. Bragdon start with you and then we will just go down the table.

Mr. BRAGDON. I think it is key for States to look at value-based purchasing not only innovative things working directly with providers in how do you get better care for individuals, and there are great examples of States doing that to promote more providers participating in the Medicaid program, where you have private plans they pay if the Medicaid patient no-shows, or in some States the plan itself coordinates travel to make sure the patient can actually get to the doctor, but it also add benefits to attract patients. So for example, adding dental benefits, all within that same fixed price, but really creating taking Medicaid like a floor and building on top of it, which I think is really key.

You have to also look at, are individuals actually getting healthier? Because that is what we want the safety net to do, is take somebody who is poor and sick and make them healthier so they have the hope of a better life. So ultimately, value based should look at, is it improving health?

Mr. GRIFFITH. Absolutely. Mr. Weil.

Mr. WEIL. States use their flexibility to set payment rates to promote plans that can demonstrate higher value through standard measures of quality and measures of access.

There is also movement towards what is known as value-based insurance design which is a specific form of value purchasing design to make it less expensive, for example, for people to get maintenance drugs for a chronic condition, maybe even free, because it is actually cheaper to give them free medication than to have them not take the medicine because of a $3 copayment. There is a whole center at the University of Michigan that is helping States and private payers in that area. It is a very active area.

Mr. GRIFFITH. Obviously not easy answers.

Mrs. Owcharenko.

Ms. OWCHARENKO. Thank you. I think that it actually what has been said is great, and what it shows is that Medicaid has seen kind of the failure of its past in trying to find ways to be more innovative and in doing things in a more efficient way. But I would caution like in the State of Virginia that those reforms should take place and those results should come through before deciding whether to now add a new expansion population into that making further the complexity of what reform is intended to achieve.

Mr. GRIFFITH. Particularly in light of the fact that the Federal Government is going to reduce the amount of money it gives back to the States for the expansion as time goes by. I do appreciate that.

Mr. Weil, I also appreciate the fact that you are concerned about rural districts. I have a rural district, and while I like the idea of having multiple plans, if folks can't get there it doesn't do us any good. So I do appreciate all of your testimony this afternoon.

And with that, Mr. Chairman, I yield back.

Mr. PITTS. The chair thanks the gentleman. That concludes the questions from the members. Thank you very much, very informative testimony today. There will be questions that members have that will be submitted to you in writing. We ask that you please respond promptly to those questions.

I remind members that they have 10 business days to submit questions for the record, and members should submit their questions by the close of business on Monday, July 22nd.

Without objection, the subcommittee is adjourned.

[Whereupon, at 5:40 p.m., the committee was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. FRED UPTON

Today's hearing is the third in a series of subcommittee hearings on the current challenges facing Medicaid programs across the country. I want to thank Chairman Pitts for his leadership on this issue and want to welcome today's witnesses.

Through the Committee process, we can continue to have a valuable discussion about the strengths and weaknesses of the current Medicaid program. As we move toward reform, I hope we will continue to gather the most relevant and timely data and state input, and continue these important discussions with Medicaid stakeholders and patients.

The Medicaid program is extremely complex and its operating structure and equally complex financing framework are often topics for reform. Many have said that if you see one Medicaid program, you still only know one Medicaid program—as every state is quite different.

Before we move forward, we must understand not only who Medicaid is currently serving, but better appreciate how well Medicaid is doing in accomplishing its goals.

Reform must ensure the path forward for a modern Medicaid program that is strong enough to face the challenging realities of scare federal and state resources. Reform must empower states and Medicaid stakeholders with the necessary flexibility to make Medicaid more than just a coverage program or card without access.

Surprising to most, Medicaid today covers more Americans than any other government-run health care program, including Medicare.

While Medicaid covered approximately four million people in its first year, there were more than 72 million individuals enrolled in the program at some point in Fiscal Year 2012—nearly 1 in 4 Americans.

Those enrollment figures on their own, and their potential drain on the quality of care of the nation's most vulnerable folks is cause for alarm. But once the president's health care law is fully implemented, another 26 million more Americans could be added to this already strained safety net program.

Medicaid enrollees today already face extensive difficulties finding a quality physician because, on average, 30 percent of the nation's doctors won't see Medicaid patients. Studies have shown that Medicaid enrollees are twice as likely to spend their day or night in an emergency room than their uninsured and insured counterparts.

Instead of allowing state and local officials the flexibility to best administer Medicaid to fit the needs of their own populations, improve care, and reduce costs, the federal government has created an extensive, "one-size fits-all" maze of federal mandates and administrative requirements.

With the federal debt at an all-time high, closing in on $17 trillion and states being hamstrung by their exploding budgets, the Medicaid program will be increasingly scrutinized over the next 10 years.

Its future ability to provide coverage for the neediest kids, seniors, and disabled Americans will depend on its ability to compete with state spending for other priorities including education, transportation, public safety, and economic development.As I noted at the opening, Energy and Commerce Committee Republicans remain committed to modernizing the Medicaid program so that it is protected for our poorest and sickest citizens. We will continue to fight for those citizens because we believe they are currently subjected to a broken system.

The program needs true reform, and we can no longer tinker around the edges with policies that add on to the bureaucratic layers that decrease access, prohibit innovation, and fail to provide better health care for the poor. In May, Senator Hatch and I introduced Making Medicaid Work—a blueprint and menu of options for Medicaid reform that incorporated months of input from state partners and policy experts from a wide range of ideological positions. My hope is that this morning's hearing is the next step in discussing the need for reform so that we can come together in finalizing policies that improve care for our most vulnerable citizens. Washington does not always know best—we have a lot to learn from our states and should better understand the challenges facing our current programs before we consider any expansion of the program.

Thank you, Mr. Chairman and I yield my remaining time to ————————.

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American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

July 8, 2013

Statement for the Record

On behalf of the
American Academy of Pediatrics

Before the
U.S. House of Representatives Committee on Energy and Commerce, Subcommittee on Health

American Academy of Pediatrics • Department of Federal Affairs
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American Academy of Pediatrics
Statement for the Record
House Energy & Commerce Subcommittee on Health
Hearing: "Making Medicaid Work for the Most Vulnerable"
July 8, 2013

The American Academy of Pediatrics (AAP), a non-profit professional organization of 62,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children adolescents, and young adults, appreciates this opportunity to provide a statement for the record for the Energy and Commerce Committee's Subcommittee on Health hearing entitled "Making Medicaid Work for the Most Vulnerable." This statement is divided into three areas focused on the importance of Medicaid to children, extending the Medicaid payment increase and renewing the federal government's commitment to pediatric quality improvement in Medicaid and other insurance systems.

Children are, by definition, a vulnerable population. Currently, pediatricians believe that poverty is the most important threat to US child health. More than one in five children lives below the federal poverty level (FPL) in the United States and almost one in two are poor or near poor. Thirty-four percent of Hispanic children in the US live in poverty. Thirty-nine percent of African-American children in the US live in poverty.

The effects of poverty on children's health and well-being are well documented. Poor children have increased infant mortality, higher rates of low birth weight and subsequent health and developmental problems, increased frequency and severity of chronic diseases such as asthma, greater food insecurity with poorer nutrition and growth, poorer access to quality health care, increased unintentional injury and mortality, poorer oral health, lower immunization rates, and increased rates of obesity and its complications. There is also increasing evidence that poverty in childhood creates a significant health burden in adulthood that is independent of adult-level risk factors and is associated with low birth weight and increased exposure to toxic stress (causing structural alterations in the brain and long-term epigenetic changes).

The consequences of poverty for child and adolescent well-being are perhaps even more critical than those for health. These are the consequences that may change life trajectories, lead to unproductive adult lives, and trap them in intergenerational poverty. Children growing up in poverty have poorer educational outcomes with poor academic achievement and lower rates of high school graduation; they have less positive social and emotional development which, in turn, often leads to life "trajectory altering events" such as early unprotected sex with increased teen pregnancy, drug and alcohol abuse, and increased criminal behavior as adolescents and adults; and they are more likely to be poor adults with low productivity and low earnings.

The Importance of Medicaid to Children

Children are the poorest members of our society, a society that knows how to use policies and programs to raise its citizens out of poverty. Medicaid is one of the most important anti-poverty programs in US federal policy, efficiently financing the periodic needs of healthy children, and helping families avoid medical bankruptcy due to the costs of medically necessary health services. Because of the incredibly widespread and corrosive nature of pediatric poverty in the US, Medicaid should be strengthened for children, not undermined.

Medicaid is also structured to address the unique needs of the pediatric population. Children are not simply little adults. The health care needs of infants, children, and adolescents are sufficiently distinct from those of adults, such that a health care system designed around the needs of adults will not meet the needs of children. The number one cause of death in U.S. children is injury, not heart disease or cancer. Meanwhile, obesity among children is epidemic. Furthermore, children are uniquely dependent upon caregivers to detect medical problems, to access health care, to translate the nature of their symptoms to clinicians, to receive recommendations for care, and to arrange for and monitor ongoing treatments. As infants and children are in constant stages of development, their capabilities, physiology, size, cognitive abilities, judgment, and response to interventions constantly change and must be continuously monitored to insure that these changes are proceeding within an acceptable trajectory. Specific attention to the unique characteristics of children must and should frame all design and financing considerations for this segment of the population.

Most children are healthy, so the epidemiology of disease is different in the pediatric population than in the adult population. Nevertheless, an important segment of children suffer from chronic conditions that affect their development and that require specific attention for generating, maintaining, and restoring age appropriate functioning. Children and youth with special health care needs constitute around 15% of the pediatric population but 40% of the pediatric "spend." Specific consideration of the unique characteristics of children must and should frame all plans for the design and financing of health care services for this segment of the population.

The economic, ethnic, and racial demographics of the pediatric population in the U.S. put children at risk of adverse outcomes due to existing health care disparities that must not be ignored. To account for these specific differences between children and adults, essential services for infants, children and adolescents must include not just preventive care but the full range of diagnostic, therapeutic, and ongoing counseling and monitoring not only of healthy children but also of those with developmental disorders, chronic conditions, behavioral, emotional and learning disabilities.

Services that are medically necessary for children are thus different than those for adults. For children, medically necessary services include prevention, diagnosis, treatment, amelioration or palliation of physical, mental, behavioral, genetic or congenital conditions, injuries, or disabilities, and these services need to be age appropriate. Treatment interventions should be evidence-based, but since large scale randomized controlled trials are significantly less plentiful for children than for adults, when that standard is lacking, observational studies, professional standards of care, or consensus of pediatric expert opinion must serve as acceptable substitutes. Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit should serve as the standard of benefits for children, alongside Bright Futures' well baby and well child periodicity schedule recommendations, in all health plans. Because EPSDT is an important cornerstone of the program, the benefit package for children in Medicaid is the gold standard of care for children.

It is a national tragedy that not every child in the US has quality health insurance. Research has consistently shown the important role that health care coverage plays in children's access to and use of health care services and their attainment of positive health outcomes. Medicaid is a vital component of the American health and social safety net, particularly for low-income children and children with special health care needs. The entitlement to Medicaid must be protected to ensure the health and well-being of millions of children.

The AAP recognizes the achievements of the Medicaid program in improving access to health care services for children. The Medicaid program provides documented improvement in health care access, preventive visits, and a usual source of care, resulting in improvement in health care outcomes and the overall health status of children. Arguments to the effect that being covered by Medicaid is worse than having no insurance are not accurate. Pediatricians also know that the U.S. health system continues to shed employer-sponsored insurance, and in particular, dependent coverage under such insurance.

Although the percentage of U.S. children with private employer-sponsored health insurance decreased from 66.2% to 53.0% from 1997-2011, the proportion covered by public insurance, including Medicaid and the Children's Health Insurance Program (CHIP), increased from 21.4% to 42.0% so that the total percent of uninsured U.S. children decreased from 13.9% to 6.6% at a time when uninsurance rates among adults were increasing.

Moreover, the reductions in uninsurance were concentrated among the target population of children in families at or below 200% of the federal poverty level. The percentage of those covered by employer-sponsored insurance in that group fell from 34.4% to 24.9%, while the percentage of those on Medicaid or CHIP increased from 41.3% to 60.4%, so that the uninsurance rate among these children decreased from 24.6% to 15.3% over this period.

Medicaid works for children, but it also works for pediatricians. The AAP and its members have made a strong commitment to the Medicaid program. In general, pediatricians serve more Medicaid patients than do other primary care physicians. On average, 30% of a pediatrician's patients are covered by Medicaid, illustrating the commitment of pediatricians to ensure that Medicaid-insured children have access to a medical home.

Because parental insurance is a predictor of children's insurance status, a state's decision to forego federal funding for Medicaid enrollment for eligible adults will have a predictable negative effect on children's coverage. The Academy urges states to expand their Medicaid programs because strong evidence suggests that children's health outcomes improve as their parents gain insurance. In addition, many children now covered by Medicaid lose health insurance as they become young adults. How states choose to respond to the opportunity afforded by the Affordable Care Act (ACA) to participate in the adult Medicaid expansion can have a great impact on many pediatric patients. Even so-called "childless adults" deserve the dignity and security of quality health insurance, and the Academy has adopted policy noting that health care is a right for everyone. The Academy plans an outreach and enrollment campaign to

raise awareness about new health insurance options for parents of children who visit pediatricians for back-to-school physicals and has pledged to work in other ways to educate the public about their new rights under established law.

Major program reforms are under consideration even as Medicaid expansion is being adopted by more states. Federal legislators have publicly discussed allowing states more flexibility in changing Medicaid rules and regulations without waivers, altering eligibility requirements, cutting benefits to optional Medicaid eligibility groups, implementing cost sharing, and offering capped funding allotments or block grants for acute and long-term care. Although children through 20 years of age represent 54% of all Medicaid enrollees, they account for only 23.5% of all Medicaid expenditures.

Consequently, state and federal cost-containment strategies targeting children are not likely to yield significant savings and, in fact, may result in far greater state expenditures. Costs do not disappear when children are cut from or drop out of the Medicaid program as a result of cost-containment strategies. States may experience higher expenditures in areas such as primary care clinics in public health departments, increased utilization of emergency departments, and an increase in the number of preventable hospitalizations. Other costs, which are more difficult to quantify, such as school absences for children and missed work for parents when children are sick as well as the adverse consequences of delayed treatment, are also likely. The AAP, therefore, continues to maintain its strong support for the Medicaid program. Nevertheless, pediatricians know that the Medicaid program could be improved and would respectfully offer the recommendations contained in the attached Medicaid Policy Statement issued by the Academy on May 5, 2013.

Medicaid Payment

The ACA increased Medicaid payment rates for primary care services to at least 100 percent of Medicare rates for calendar years 2013 and 2014. This landmark investment in improving access to care for children in the Medicaid program should serve as an important indicator of the federal government's recognition that payment rates in Medicaid have been subpar. The AAP strongly believes that Congress should make federal support for these payment rates permanent, extend the increase to all pediatric codes, and extend the provision to all pediatricians, including all pediatric subspecialists.

For decades, the Academy has fought to ensure that meaningful access to health services is available to children in the Medicaid program. Prior to 2013, Medicaid rates averaged below 70 percent of Medicare rates for primary care services and were simply insufficient to cover the costs of providing care. For many services and in many states, payment was even lower.

Pediatricians and other health care providers need to be focused on treating and caring for our children, not distracted by the inadequacy of payment rates. Nationally, pediatricians provide a majority of all office visits (65.7 percent) to children on Medicaid. Without consistent payments,

fewer physicians are able to participate in Medicaid, threatening children's access to quality health care.

While the change to improve payments has been delayed in many states, it has been reported that at least 42 states will be providing the payment increase in their fee for service programs by the end of this month and that only ten states do not have an approved Medicaid managed care methodology. Additionally, the AAP's chart noting how to apply for the increase has been downloaded more than 12,000 times. There is clearly deep interest in making this program work.

The Academy strongly believes that appropriate payment rates are needed to provide real access to care. Ultimately, children will lose if Congress fails to address low payment rates under Medicaid. There is solid evidence that appropriate payment to pediatricians will result in children having better access to comprehensive health services in a medical home.

Quality

The Academy applauds Congress' continuing Bipartisan focus on improving the quality of care in the Medicare, Medicaid, and CHIP programs. In particular, the AAP noted with deep interest, pages 15-16 of Chairman Upton's "Making Medicaid Work," which argues for more standardized reporting on quality within Medicaid programs. Congress and the American people deserve to know what their tax dollars are buying and thus, we would urge that the Subcommittee, full Committee, and Congress require or incentivize a uniform level of quality reporting in Medicaid.

Building on the commitment to improve quality of care in Medicaid and CHIP found in CHIPRA's Title IV, the Academy has worked with other organizations (the American College of Obstetricians and Gynecologists, the March of Dimes, the Children's Hospitals Association, Nemours, the National Partnership for Women and Families, and the National Institute to Improve Child Health Quality) to produce an agreement regarding a renewed federal focus on maternal and child health quality.

Title IV of CHIPRA created important initiatives to advance the quality of care for children and pregnant women. By enacting Title IV, Congress provided critical direction and funding to address the inequity created by Medicare driving quality improvement that focuses primarily on seniors. As a result of Title IV, virtually every state Medicaid program is now engaged in pediatric and maternity quality improvement efforts, and a number are engaged in projects involving the private sector as well. In just a few short years, CHIPRA's quality provisions have set in motion significant changes in both pediatric and maternity care that should be sustained and enhanced.

These organizations' joint recommendations to improve CHIPRA's impact on quality follow:

1) Extend the authority and funding provided under section 401(i) beyond fiscal year 2013.

2) Continue funding for the Centers of Excellence program and encourage the development, implementation and stewardship of measures that can be used at the state, hospital, practice and/or plan level.
3) Expand efforts to spread the use of the CHIPRA and Medicaid core set of measures and other measures developed through the Pediatric Quality Measures Program across different health care delivery and coverage systems.
4) In consultation with the states and relevant medical provider organizations, within one year of the provisions' extension develop a plan to require states to report on the full complement of pediatric core set measures within five years of the provisions' extension, and provide enhanced federal funding and technical assistance to states for these activities.
5) Continue the authority and current funding level for Section 401(d), the demonstration projects program that allow states and providers to spread successful quality improvement practices for children, and extend its efforts to examine perinatal care.
6) Modify the electronic health records program to include CHIP in case mix calculations that allow for incentive payments under the HITECH Act.

Title IV of CHIPRA has achieved remarkable results in the few short years since its passage. We commend you once again for your vision and leadership in establishing these landmark provisions and urge your attention to maternal and pediatric quality improvement as discussions on how to solve the Medicare Sustainable Growth Rate formula move forward. If Medicare includes a quality improvement component to justify continued payment rates and children and pregnant women are excluded due to the nature of the Medicare program, a parallel system for children and pregnant women is strongly justified. It would be a missed opportunity to exclude children and pregnant women yet again simply because of the nature of Titles XVIII, XIX and XXI of the Social Security Act.

We appreciate your willingness to consider the recommendations of the American Academy of Pediatrics and look forward to working with you to continue these important efforts to improve the health of the Medicaid program, and ultimately the health of children.

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Medicaid Policy Statement

COMMITTEE ON CHILD HEALTH FINANCING

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American Academy of Pediatrics
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FROM THE AMERICAN ACADEMY OF PEDIATRICS

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

POLICY STATEMENT

Medicaid Policy Statement

COMMITTEE ON CHILD HEALTH FINANCING

KEY WORDS

Medicaid, Child Health Insurance Program, benefits, coverage, financing, payment, eligibility, outreach, enrollment, managed care, quality improvement

ABBREVIATIONS

AAP—American Academy of Pediatrics
AARA—American Recovery and Reinvestment Act
ACA—Patient Protection and Affordable Care Act
CHIP—Children's Health Insurance Program
CMS—Centers for Medicare and Medicaid Services
CPT—*Current Procedural Terminology*
DHHS—Department of Health and Human Services
EHB—essential health benefits
EPSDT—Early and Periodic Screening, Diagnosis and Treatment
FMAP—federal medical assistance percentage
FPL—federal poverty level
HMO—health maintenance organization
MCO—managed care organization
MOE—maintenance of effort
PCMH—patient-centered medical home

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Medicaid insures 39% of the children in the United States. This revision of the 2005 Medicaid Policy Statement of the American Academy of Pediatrics reflects opportunities for changes in state Medicaid programs resulting from the 2010 Patient Protection and Affordable Care Act as upheld in 2012 by the Supreme Court. Policy recommendations focus on the areas of benefit coverage, financing and payment, eligibility, outreach and enrollment, managed care, and quality improvement. *Pediatrics* 2013;131:1–10

HISTORY OF MEDICAID PROGRAM

The Medicaid program was enacted in 1965 as Title XIX of the Social Security Act with funding streams derived from both federal and state governments. All states have participated in this voluntary program since Arizona joined in 1982. Federal law designates which groups of people must be eligible for Medicaid enrollment and what core medical benefits must be provided. Each state may then expand eligibility criteria, enhance benefits, contract with managed care organizations (MCOs) to administer the Medicaid program, and apply for waivers to develop specialized programs for particular populations. For instance, states have had the option to enroll children whose families have an income at or below 200% of the federal poverty level (FPL) in Medicaid, although only 6 states had chosen to do so by 1997 when the State Children's Health Insurance Program (CHIP) was enacted by Congress as Title XXI of the Social Security Act.

By 2009, total Medicaid enrollment had grown to include 34.2 million infants, children, and adolescents younger than 21 years. Medicaid provided benefits to 39% of the US pediatric population and covered 48% of all births. In 2009, Medicaid payments to providers for all age groups had expanded to $326.0 billion.* Although children younger than 21 years represented 53% of all Medicaid enrollees, they

*These figures differ from the Medicaid data provided by the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary[1] for several reasons. The higher CMS estimate of total Medicaid costs for fiscal year 2009 of $380.6 billion includes nonprovider expenses such as disproportionate share hospital payments, administration costs, the Vaccines for Children Program, and other adjustments. Calculated costs per participant also differ for 3 reasons: (1) CMS uses estimated "person-year equivalents" (50.1 million) for fiscal year 2009 rather than "ever participants" (62.9 million unique participants covered by Medicaid for at least 1 month) as the basis for the calculation; (2) the AAP considers 19- and 20-year-old participants to be children, whereas CMS considers them to be adults; and (3) CMS segregates both children and adults who are blind and/or disabled into a separate "disabled" category.

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accounted for only 29% of all Medicaid provider payments. In 2009, Medicaid expenditures averaged $2630 per child younger than 21 years compared with $6459 per adult between the ages of 21 and 64 years and $11 812 per senior citizen 65 years or older.[2]

Except for a few special programs (eg, family planning services, American Indian/Alaskan Native populations, administrative costs), the federal government funds a different proportion of each state's Medicaid budget.[3] This federal medical assistance percentage (FMAP) for each state is based on a formula that relates the 3-year rolling average per capita income in the state to that for the entire United States. By law, the minimum and maximum FMAPs are 50% and 83%, respectively.[3] Before the passage of the 2009 American Recovery and Reinvestment Act (ARRA: Pub L No. 111-5), the FMAP varied across states from 50% to 76%. Under ARRA and other FMAP "extension legislation" (Education, Jobs, and Medicaid Assistance Act of 2010 [Pub L No. 111-226]), FMAPs temporarily increased through June 2011 (eg, to a range of 62%–85% in the second quarter of fiscal year 2010). These enhanced FMAPs transiently decreased state Medicaid expenditures for fiscal year 2009 through fiscal year 2011. However, with the sunset of ARRA FMAP legislation and more Medicaid beneficiaries due to continued poor economic conditions and other factors, state Medicaid costs increased sharply in fiscal year 2012 and are expected to continue to climb through fiscal year 2019.[4]

[4]Beginning in 2020, the federal government will still fund 90% of the additional costs associated with newly eligible participants under the ACA. If the ACA Medicaid expansion were to be adopted by all states, the Congressional Budget Office had estimated that the total increased cost of the Medicaid program attributable to Medicaid expansion from 2014 to 2019 would be $564 billion dollars, of which $500 billion, or 89%, would have been funded by the federal government.[5]

IMPACT OF THE ACA AND THE 2012 SUPREME COURT DECISION ON THE MEDICAID PROGRAM

Passage of the Patient Protection and Affordable Care Act (ACA)[3] in 2010[4] profoundly changed the Medicaid program through its expansion of Medicaid eligibility to all legal residents younger than 65 years with individual or family incomes at or below 138% of the FPL.[5] Hence, the ACA not only added a large population of adults (ages 19 through 64) who became newly eligible for Medicaid, but in many states, the expansion also increased the number of eligible children (through age 18) by mandating a higher minimum income eligibility.[6] The ACA directed the federal government to fund Medicaid expansion in full through 2016 and then at lower but still significant levels thereafter (tapering to 90% funding by 2020). The landmark Supreme Court decision upheld the constitutionality of the ACA with respect to the contested "individual mandate" for every American to obtain health insurance by a 5 to 4 margin.[5] However, the Court also struck down as unconstitutional an enforcement provision of the ACA that would have allowed the Department of Health and Human Services (DHHS) to withhold all federal Medicaid funding from states that declined to participate in Medicaid expansion. By a 7 to 2 majority, the Court ruled that this provision constituted undue coercion on states by the federal government; in a remedy, however, the Court upheld the constitutionality of the Medicaid expansion as an individual state option.

[3]Encompassing the Patient Protection and Affordable Care Act and the amendment law associated with that act, the Health Care and Education Reconciliation Act (Pub L No. 111-152).

[5]The ACA established a new national floor of Medicaid coverage at 133% of the FPL with a standard 5% of income disregard that constituted part of a simplified modified adjusted gross income calculation designed to harmonize means-tested eligibility (Medicaid disregards the first 5% of one's income before calculating the proportion to the FPL). The ACA had mandated a minimum income level for Medicaid eligibility at 138% of the FPL beginning in 2014.

[6]The number of children newly eligible for Medicaid in a given state as a result of the change in qualifying FPL will depend on that state's current choice of percentage of FPL as the eligibility criterion for Medicaid for older children as well as that state's implementation of and enrollment within CHIP. There are currently 2.8 million children below 138% of the FPL who are not currently insured by Medicaid or by CHIP. In addition, an unknown number of children with family incomes between 100% and 138% of the FPL who are currently insured by CHIP would rollover to Medicaid coverage and about 4.3 million children with family incomes between 100% and 138% of the FPL who are now covered by private insurance would potentially be eligible for Medicaid.

Legal scholars generally agree that the narrowly written Court decision did not invalidate other changes made by the ACA to the Medicaid program that pertained to existing populations.[8] The constitutionality of 3 provisions in particular has special importance for the pediatric population. First, Section 2001(b) of the ACA imposes a "maintenance of effort" (MOE) requirement that disallows states from restricting eligibility or reducing benefits for current child Medicaid beneficiaries until 2019. Second, Section 2001(a) (5) (b) expanded Medicaid eligibility for children under 19 by raising the minimum qualifying family income level to 138% of the FPL. Third, the ACA required states to improve outreach to and simplify enrollment of any person currently eligible for Medicaid.[6]

Many children now covered by Medicaid lose health insurance as they become young adults, so that how states choose to respond to the opportunity afforded by the ACA to participate in the adult Medicaid expansion can have a great impact on many pediatric patients. It is likely that additional negotiations will ensue in the future between the secretary of the federal DHHS and state Medicaid agencies that have initially

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signaled reluctance to pursue full-scale Medicaid expansion.[6]

This revision of the American Academy of Pediatrics (AAP) Medicaid Policy Statement advocates for the provision and funding of children's services in the Medicaid program and highlights changes in or new opportunities for state advocacy efforts as a result of the passage of the ACA and the 2012 Supreme Court decision.

The AAP continues to voice strong support for the Medicaid program and over the years has offered a continuing series of recommendations aimed at enhancing care and improving outcomes for children.[7] In particular, the AAP has long advocated innovative approaches to care (such as pediatric medical homes) that aim to achieve better health outcomes while reducing costs of care. The AAP stands ready to support newer population health-based programs (eg, Medicaid accountable care organizations) that seek to attain those same objectives. AAP members have been integral providers in both regular Medicaid and in state-specific Medicaid waiver programs and consequently have working experience with reform efforts of varying success.

BENEFITS AND MEDICAL HOME

Beyond a core set of mandated benefits, federal guidelines provide states with wide discretion in benefit design. The AAP recommends that all state Medicaid agencies:

1. Provide all children at a minimum the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit and all other mandatory and optional benefits as outlined in the AAP statement "Scope of Health Care Benefits for Children From Birth Through Age 26."[8] Ensure that the medical necessity definitions used by each state for purposes of justifying medical services covered by Medicaid payment are consistent with the EPSDT policy. Furthermore, each state's process for determining medical necessity should rely on the expertise of pediatricians, pediatric medical subspecialists, and pediatric surgical specialists. Ensure that in the process of making decisions on the basis of medical necessity, the medical, behavioral health, and developmental care needs of the child are fully considered and that appropriate comprehensive benefits are available to address the full range of these needs.[9]

   Develop appropriate benefits that address the needs of pregnant women. Pregnant women should be afforded the full range of maternity care (preconception, prenatal, labor, delivery, and postpartum) recommended in the Guidelines for Perinatal Care issued jointly by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics. Detail the full scope of pediatric Medicaid benefits in consumer brochures, on Web sites, and, most importantly, in state plan documents and managed care contracts. State agencies should provide a clear comparison of pediatric Medicaid benefits and networks among managed care plans so that families can choose a plan that is most appropriate for the needs of their child(ren).
2. Provide pharmacy benefits appropriate for children and broad enough to pay for medicines and specialized nutritional products required for children with special health care needs and for children with rare diseases. State Medicaid Pharmacy and Therapeutics committees should populate and operate a pediatric formulary with the recognition that less expensive (usually generic) drugs may not be as effective as alternative but more costly (usually brand name) drugs of the same class in all patients under all circumstances. Pharmacy benefits should acknowledge that many medications are appropriately prescribed to children in the absence of a pediatric label indication or dosing information. Optimally, states should mandate that all Medicaid MCOs operating in the state adopt the same state pediatric Medicaid formulary to ensure continuous and consistent treatment of patients (especially those with special health care needs or rare diseases) because they often transition between Medicaid insurers.
3. Ensure that all children have timely access to appropriate services from those qualified pediatric medical subspecialists and pediatric surgical specialists who are needed to optimize their health and well-being.
4. Ensure that Medicaid provider networks are sufficient to guarantee that children who transition from pediatric to adult care providers do not experience disruption in services.
5. Adopt periodicity schedules as defined in the AAP guidelines.[10] Immunization schedules should also be consistent with national guidelines as periodically revised by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, the American Academy of Pediatrics, and the American Academy of Family Physicians.[11]

New or continuing efforts in which the AAP and its members can participate that can result in enhanced benefits for children enrolled in Medicaid programs include the following:

1. Develop and then facilitate the implementation of a working pediatric medical home model that

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incorporates Bright Futures guidelines[12] and treatment services as codified in EPSDT.

2. Work with Medicaid and private insurance companies to standardize parameters for the medical home concept.[13,14] The wide variation in both panel size and family demographics encountered across pediatric practices suggests that a variety of models may be needed.
3. Develop and direct a program that educates parents, patients, and physicians about the advantages of a pediatric medical home.[15]
4. Partner with AAP state chapters, other pediatric health care providers, and families with children who are Medicaid beneficiaries to monitor and recommend improvements to state Medicaid programs and to the Centers for Medicare and Medicaid Services (CMS).
5. Assist parents, patients, and physicians to understand the full scope of Medicaid benefits.

FINANCING AND PAYMENT

Medicaid fee schedules and capitated payments to primary care and subspecialty providers are significantly lower than payments for comparable services from Medicare and private insurance companies. Low Medicaid payment is the primary reason that physicians limit participation in the program with resulting barriers to patient access for primary care and subspecialty health care services.[16–22] Even at academic medical centers that serve as "safety nets" for uninsured or underinsured patients, reduced access may be reflected by significantly longer wait times for subspecialty care.[23] Hence, the initial intent of Title XIX to provide truly equal access to quality primary and subspecialty care has not been fulfilled. Other documented reasons why providers decline or limit participation in Medicaid include delayed or unpredictable payments, confusing or burdensome payment policies and paperwork, and nonadherence to scheduled visits.[17,18,22]

Although the MOE provision in the ACA proscribes states from restricting their current Medicaid eligibility rules until 2019 for children, states may choose instead to reduce their expenses by limiting nonmandatory services for adults, trimming payments for services, revoking any higher payments to specific groups of physicians, and cutting hospital payments. States have voiced alarm that high unemployment rates and increasing numbers of families enrolled in Medicaid will critically affect their budgets. In addition, as the US population ages, the growing number of seniors who become eligible for Medicare will also swell the ranks of seniors dually eligible for Medicaid coverage. The CMS Office of the Actuary has estimated that if each state fully implemented the ACA Medicaid expansion, state Medicaid expenditures would more than double over the decade from 2009 to 2019, from $132.3 billion to $313.3 billion.[24] To the extent that any state chooses to participate in the ACA Medicaid expansion, it will be vital that federal and state governments not compromise necessary coverage for children nor fail to provide adequate payment for pediatric care. In addition, states must be cognizant that ACA discontinued federal disproportionate share hospital payments to all states, anticipating that Medicaid expansion to the adult population would provide replacement revenue for safety net hospitals. Hence, states that choose not to participate in Medicaid expansion may risk the viability of some safety net hospitals.

In 2011, Medicaid payments for evaluation and management services across all states averaged ~64% of the Medicare rates and lagged even farther behind payments by private insurers.[25] The ACA provides federal funding to Medicaid programs and state-financed Medicaid managed care plans to pay eligible physicians at Medicare rates for certain evaluation and management services, preventive care, and immunization administration during 2013 and 2014 (but not subsequently), including well-child ("checkup") codes (*Current Procedural Terminology* [CPT] codes 99381–99385; 99391–99395). Payment at this level should be sustained beyond 2014 and expanded to include all Medicaid services. This will require intense federal and state-specific advocacy.

The AAP proposes the following recommendations for federal and/or state action:

1. Ensure that Medicaid payments to providers for the goods and services involved in caring for children not only pay for the related work and practice expenses but also provide a sufficient return to make continued operation of a practice or facility economically feasible. In a broader context, payments should be sufficient to enroll enough providers and facilities so that, as required by federal law, Medicaid patients have "equal access" to care and services as do nongovernmentally insured patients in that geographic region. Failure to provide this fair level of payment will lead to continued early attrition of current pediatric providers as well as failure to attract physicians to pursue careers in primary or subspecialty pediatric care. To achieve this aim, the AAP recommends the following:
   a. Increase base Medicaid payment rates for all CPT codes, including pediatric specific CPT codes (eg, well-child checkup,

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counseling, and developmental assessment), to all providers to the 2012 or 2009 regional Medicare fee schedule rate, whichever is higher, or, in the case of preventive services without a Medicare payment, to a rate calculated by applying Medicare fee schedule methodology to the published values of work, practice expense, and professional liability insurance relative value units adjusted for the geographic region. These payment rate principles should be made permanent (ie, extended beyond the 2014 termination date) with the minimum level of payment per CPT code established as the greater of the 2012 Medicare actual or calculated rate or the current year's rate.

b. Establish a methodology to provide additional fair payment to a practice that recognizes the extra resources that might be invested on behalf of its Medicaid patients to promote wellness (eg, to pay for more vigorous outreach to increase participation rates with well-child checkups) and to provide care coordination of infants and children with complicated physical and/or mental health illnesses (eg, to pay for care coordinators, social workers, extended office hours, home visitations, dental care, durable medical equipment, etc). At present, fee-for-service payments (even if increased to Medicare rates) and current Federally Qualified Health Center payments do not fully pay for these extra resources.

c. Reward practices that meet or exceed AAP-approved predefined quality and performance metrics with incentive payments.[26]

d. Require Medicaid managed care plans to determine payment based on the principles outlined in (a) and (b) so that pediatric providers and patient-centered medical home (PCMH) programs are appropriately compensated. Similarly, require managed care plans to make providers eligible for additional incentive payments, as in (c), if, for instance, providers demonstrate improved outcomes, reduction of total Medicaid costs, and robust efforts to transition children with special health care needs to adult care. Provide input to Medicaid managed care plans about possible designs and implementations of structured incentive programs based on quality and performance parameters advocated by the AAP.

e. Explore the feasibility of adjusting fee-for-service or capitated payments to a provider on the basis of a risk-adjustment mechanism that accounts for the extra costs associated with caring for children with chronic conditions and other key pediatric diagnoses among the children in the provider panel.

f. Establish a mechanism within state Medicaid agencies and Medicaid MCOs for rapid adjustment of fee-for-service or capitated payments to providers for recommended new vaccines and other new technologies that rapidly achieve translation from clinical trials to standard clinical practice.

g. Require that paperwork in support of claims is not unduly burdensome and that clean claims are paid within 30 to 45 days of submission, so that practices can meet their cash flow obligations.

2. Oppose the conversion of Medicaid financing to an annual allotment or block grant programs with a fixed budget. Block grant proposals typically result in cost shifting from federal to state budgets and do not reduce overall health costs or improve quality of care. In fact, institution of block grants in combination with revocation of the MOE provision in ACA would likely restrict eligibility and reduce benefits for children to result in the loss of the individual child's guarantee to access Medicaid services. Recently, the concept of using "per capita caps" to control Medicaid expenditures has resurfaced, but ultimately, this mechanism of funding poses the same risks for children as do block grants.

3. Work with the AAP to study the feasibility of implementing pediatric-specific accountable care organizations through carefully structured demonstration projects.[27,28]

4. Pay primary care physicians for behavioral health services that physicians are qualified and competent to provide. Eliminate carve-outs for behavioral health coverage.

5. Mandate that states perform an in-depth assessment of the fiscal viability of any health plan before contracting with that plan to administer a Medicaid program and conduct annual audits to verify continued fiscal stability of the health plan. Require states that contract with MCOs to publish their physician payment methodologies and rates for each child eligibility group on an annual basis.

6. Advocate for federal and state agencies to partner with organizations, such as the AAP, to educate

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physicians about programmatic changes in Medicaid fee-for-service or managed care environments (eg, pay-for-performance and PCMH programs). Physicians should understand the quality and cost control objectives of new initiatives and the linkage between fully documenting achievement of these goals and payments to physician practices.

7. Pay for the administration of immunizations (including multiantigen vaccines) and for counseling using the current CPT code set. Payments for vaccines should be at least 125% of the current Centers for Disease Control and Prevention private sector price list and payment for immunization administration should be, at minimum, 100% of the Medicare rate for each vaccine administration CPT code.
8. Ensure, wherever possible, the availability of at least 2 financially viable Medicaid MCOs in every region to allow for patient choice. Requests for proposals for organizations to serve as Medicaid third-party administrators and the ensuing selection process should be fully transparent.
9. Explore innovative methods to establish trust funds to support graduate medical education specific to the provision of primary and subspecialty care for Medicaid participants that will help maintain a qualified pediatric provider workforce.
10. Require Medicaid to provide full payment for trained interpreter services for patients with limited English proficiency. This will assist in thorough and accurate communication between provider and participant, increased accuracy of diagnosis and more appropriate treatment plan, and increased participant understanding and adherence to treatment, thus avoiding adverse clinical consequences.
11. Pay for observational care, urgent care, day medicine services, and necessary interhospital transport services, including transport of neonates from tertiary or quaternary neonatal or pediatric intensive care units to step-down convalescent units.
12. Implement policies and procedures to ensure equitable and prompt payment to providers and facilities for pediatric services rendered to Medicaid patients out of state. States should work together and with the federal government to achieve uniform and seamless processes to pay for these services.
13. Require all payers to report financial data on an annual basis so that the medical loss ratios (the percentage of total funding that is spent on patient care functions) are clearly delineated and transparent to the public.
14. Require states to develop clear and transparent rules and regulations related to ACA provisions for recovery audit contracting processes. Each state must ensure that physicians who are licensed and have practiced in the state supervise the work of certified professional coders with expertise in pediatric primary and subspecialty care. Key stakeholders, including physicians and the public, must have direct input in the process to avoid flawed statistical analysis. Payment errors due to both undercoding and overcoding should be included in a final reconciliation report. A clear and fair appeals procedure that is accomplished in a timely manner must be part of the formal recovery audit contracting process.

ELIGIBILITY

The AAP endorses the ACA-mandated expansion of Medicaid eligibility to include all children who live in families with an income below 138% of FPL.[¶] The AAP recommends that states implement the following additional measures to facilitate enrollment of children eligible for Medicaid or CHIP benefits:

1. Remove the 5-year waiting period for eligible children and/or pregnant women who are lawfully residing in the United States consistent with the provisions of the CHIP Reauthorization Act (Pub L No. 111-3).
2. Identify uninsured children who are not financially eligible for Medicaid and if possible facilitate enrolling them in CHIP.
3. Ensure that children who are moved by the state into a foster care program are tracked and immediately enrolled in and covered by Medicaid until age 21 using the Chafee option.[#] In 2014, if chosen by the foster child alumna, Medicaid coverage becomes mandatory under the ACA until age 26.
4. Ensure that newborn infants eligible for Medicaid are assigned to a specific plan immediately after birth so that timely provision of services in the first few months of life is not impeded by anticipated difficulties in payments of claims.

OUTREACH, ENROLLMENT, AND RETENTION

The AAP recommends that states strengthen their outreach, enrollment, and retention efforts to enroll all eligible uninsured children in Medicaid, CHIP, or exchange coverage.

[¶] For fiscal year 2012, the FPL thresholds are $15 415 for a single adult and $31 809 for a family of 4, with the exception of Alaska and Hawaii, where thresholds are 25% and 15% higher, respectively.

[#] A Medicaid option, known as the Chafee option, allows states to extend Medicaid to former foster children but only up to age 21. Currently, there are 21 states that use the Chafee option to provide health care coverage to former foster youth (Chafee Foster Care Independence Act of 1999).

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1. Use multiple sites and replicate other effective strategies as have been implemented in CHIP to maximize and maintain enrollment of individuals eligible for Medicaid.
2. Optimize coordination of Medicaid, CHIP, and exchange program outreach through the use of streamlined eligibility determination, redetermination and enrollment processes including the use of short and easily understood common application forms, and expanded use of online enrollment. Once a child is enrolled, coverage should continue for 12 months.
3. Consider using the medical home to enroll patients and provide a fair payment for the administrative expense of this procedure.
4. Adopt practices that result in a "no wrong doors" approach to enrollment. All venues for Medicaid, CHIP, and exchange program enrollment should be able to evaluate an applicant's eligibility for any of these programs and to process the appropriate application.
5. Advocate support for federal policies to provide incentives to states to increase enrollment and retention in Medicaid and to continue those incentives for CHIP programs.

MANAGED CARE

In recent years, fiscal and policy considerations have encouraged states to contract with MCOs to administer the Medicaid program. As of fiscal year 2009, an estimated 61% of Medicaid beneficiaries 0 through 20 years of age were enrolled in a Medicaid health maintenance organization (HMO).[2] The AAP recommends that all MCOs should adopt a pediatric medical home model for all children that adequately addresses their needs, including those with special health care needs. Network adequacy should be determined by periodic evaluation of the number of Medicaid providers whose panels are open to all new Medicaid patients.[29]

The AAP recommends that states adopt the following minimum set of practices and standards in their approach to Medicaid MCOs:

1. Ensure that MCOs (these may be either HMOs or provider-sponsored networks) provide educational materials to families that are culturally effective and written at literacy levels and in languages used by Medicaid recipients. The use of audiovisual aids should be encouraged.
2. Provide appropriate written, oral, and Web-based information and counseling to Medicaid eligible patients that allow informed patient choice of MCO-based network options for primary care physicians, pediatric medical subspecialists and pediatric surgical specialists, and pediatric hospital and ancillary services.
3. Assign Medicaid participants to an MCO that allows retention of the patient's medical home.
4. Recognize that pediatricians are primary care physicians who are eligible for pediatric patient assignment in all default enrollment systems.
5. Ensure that the provider network of all Medicaid MCOs contains the following components:
   a. Sufficient numbers of providers trained in primary care and subspecialty pediatrics, as well as pediatric surgical specialists.
   b. Sufficient numbers of physicians and other licensed providers of oral health, mental health, developmental, behavioral, and substance-abuse services so that medically necessary services are accessible within a reasonable length of time.
   c. When possible, a minimum of 1 hospital that specializes in the care of children.
   d. Vendors of durable medical equipment and home health care agencies that have experience caring for children, especially those with special health care needs.
6. License an MCO as a pediatric Medicaid provider only if its comprehensive pediatric network can provide children with quality care across the full continuum of care and hold that MCO accountable.
7. For Medicaid programs to be responsive to the needs of both patients and providers, it is essential that the programs be subject to either competition among at least 2 and when possible 3 MCOs in a region or to regulation that is regularly updated to reflect continuing input from patients and providers. Provider service networks (not-for-profit organizations created and governed by providers) should be evaluated and approved on a level playing field with HMOs.
8. Require that Medicaid administrative processes such as site visits and audits are simplified to minimize the burden for providers and office staff. Results of these processes should be available as a report card and transparent to prospective Medicaid enrollees.
9. Implement dedicated planning and oversight when MCOs contract for care delivery to children with special health care needs (including children with complex and/or rare diseases, children with behavioral/mental health conditions, and foster care children).
10. Establish an All Payer Claims Database and require MCOs to participate fully in reporting encounter

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data. This would allow health policy analysts and researchers in government, academia, and the private sector to examine regional patterns of utilization, access to care, and quality of care and inform efforts to construct "best practice" models of care.

QUALITY IMPROVEMENT AND PROGRAM INTEGRITY

The AAP recommends that, as appropriate, CMS and the AAP, or state Medicaid agencies and state AAP chapters, should work collaboratively to develop and/or enhance quality-improvement activities that can benefit all children.

1. CMS should encourage collaboration among the Agency for Healthcare Research and Quality, the National Committee for Quality Assurance, the National Quality Forum, the AAP, and the CHIP Reauthorization Act Pediatric Healthcare Quality Measures Centers of Excellence. These organizations can evaluate current quality and performance measures with a goal of recommending modifications or achieving consensus around new measures that pertain to pediatric patients, including children with special health care needs. These measures should align with the recommendations outlined in the AAP policy statement "Principles for the Development and Use of Quality Measures."[26]
2. States should require health plans to use the core set of pediatric quality improvement measures that were created as part of the CHIP Reauthorization Act. These measures quantitate access to care, utilization of services, effectiveness of care, patient outcomes, and satisfaction of both patients and providers related to preventive, primary, acute, and chronic care for children. States should develop mechanisms for public reporting of these measures that allow Medicaid beneficiaries to compare outcomes among MCOs. Consistent with federal statute, states should require that all Medicaid programs provide access to quality primary and subspecialty pediatric care that is equal to that achieved through private payers ("equal access" mandate).
3. At a minimum, states should establish Medicaid Advisory Committees whose membership includes pediatric primary care and subspecialty providers. These committees can advise state Medicaid agencies on issues related to the identification, implementation, and evaluation of quality measures and improvement programs as well as issues related to eligibility, enrollment, formulary, network adequacy, access, and medical necessity. To achieve maximal benefit, each state Medicaid agency should employ a physician with pediatric expertise who can continuously assist the agency with these issues as they relate to pediatrics.
4. Federal and state agencies should work with the AAP to develop tools and measures to monitor potential changes in the quality of pediatric care and the outcomes of the pediatric population. These tools and measures will be helpful in evaluating the effect of PCMHs and the impact of reform on children with special health care needs.
5. States should assume central responsibility for key administrative procedures that pertain to all Medicaid providers. These procedures could include meaningful provider assessment, education (eg, fraud and abuse training), and credentialing activities that would apply for all payers within the Medicaid or CHIP programs.
6. States should report results of peer review and reviews of medical records in a timely manner to providers, plans, and beneficiaries consistent with applicable federal and state laws related to confidentiality, peer review privilege, and care review privilege.
7. States should monitor enrollment patterns and develop prospective means to assess reasons for changes in enrollment to ensure that MCOs do not encourage children with a high level of need to switch to other plans.
8. States should provide timely, meaningful, linguistically and culturally appropriate summaries of quality and performance measure and programs to beneficiaries to guide their choice of Medicaid plan.

CONCLUSIONS

By 2019, if the ACA Medicaid expansion were to be implemented by all states, 16 million additional individuals would gain insurance coverage through Medicaid and CHIP. Regardless of state variations in participation in the ACA Medicaid expansion, Medicaid will remain as the largest single insurer of children.[30] Additional legal proceedings and federal/state negotiations may clarify how DHHS will implement Medicaid expansion in the new adult population. In the meantime, the AAP supports state chapter advocacy efforts to expand Medicaid to the newly eligible population. Although AAP chapters might not take the lead in advocacy, they can provide pediatric expertise to coalition efforts and highlight the positive effects expansion will have on young adults.

To date, governmental health policy on both state and federal levels has not adequately met the medical, behavioral, and developmental needs of children. The ACA has provided a framework to redress some of these deficiencies. The AAP, through its network of chapters, sections, committees, councils, and staff and in partnership with other

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allied organizations, can collaborate with both federal and state agencies to monitor implementation of those aspects of the ACA that promise to enhance the care and outcomes of children and young adults and perhaps suggest refinements for future regulations. Success in these endeavors will not only enhance the health and well-being of the children for whom pediatricians care but also will enrich our ability to provide the quality of care to which we aspire.

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Medicaid Policy Statement
COMMITTEE ON CHILD HEALTH FINANCING
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July 29, 2013

Ms. Nina Owcharenko
Director
Center for Health Policy Studies
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214 Massachusetts Avenue, N.E.
Washington, D.C. 20002

Dear Ms. Owcharenko:

Thank you for appearing before the Subcommittee on Health on Monday, July 8, 2013, to testify at the hearing entitled "Making Medicaid Work for the Most Vulnerable."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions by the close of business on Monday, August 12, 2013. Your responses should be mailed to Sydne Harwick, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to **Sydne.Harwick@mail.house.gov**.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment

Questions for the Record Responses
Ms. Nina Owcharenko, The Heritage Foundation

The Honorable Michael Burgess

1. Low provider reimbursement rates are a large factor in the decreasing number of primary care providers willing to accept Medicaid patients. How can the federal government ensure provider rates are set at levels that encourage provider buy-in?

   The best solution to encourage provider buy-in is to fundamentally reform Medicaid by moving towards a defined contribution model where the government sets contribution level which could vary by category of eligibility and allows physicians to negotiate with the private insurers for participation.

2. As you are aware, the ACA attempted to address Medicaid's low reimbursement rates by offering a short-term increase in payments to primary-care physicians. Do you know who is responsible for paying for these increased reimbursement rates? Who would pay for these increased rates past 2015? How will this increased cost affect future funding levels for Medicaid and state budgets? Do you believe these increased primary-care rates have increased the number of participating physicians in the Medicaid program?

   Federal taxpayers are responsible for funding the increased reimbursement rates included under the ACA. After 2015, when the additional federal funding ends, state would choose whether or not to maintain the higher payment levels. At the time of enactment, the Congressional Budget Office estimated the federal payments would be $8.3 billion between 2010-2019 while the Center for Medicare and Medicaid Services estimated the cost at $11 billion between 2010-2019. Of course if states were to maintain the higher payment level, states would have to budget for that increase. With delays in implementation, the impact of the provision is still unknown.

Questions for the Record Responses
Ms. Nina Owcharenko, The Heritage Foundation

The Honorable Gus Bilirakis

1. In a recent hearing on Medicare benefit redesign, I asked the panel would it be worthwhile to have the government set an actuarial value and allow for multiple Medicare plans in the marketplace. With Medicaid, at least in Florida, we seem to have taken steps to do that. Consumers may have 31 different benefit packages to choose among, that may be more options than consumers have in the Health Exchanges. Is it a good idea to provide diversity of plan options to Medicaid beneficiaries?

   Diversity of plan option would be a good idea especially in light of the diversity in Medicaid beneficiaries – children, pregnant women, the disabled, low income elderly, and in some cases also parents and childless adults. Moreover, it would allow plans to tailor benefit packages to better meet the unique needs and manage the care for enrollees.

2. The Administration seems focused on expanding Medicaid. How many people are Medicaid eligible and are not enrolled? Shouldn't we be focused on getting care to those groups before we focus on expanding Medicaid? Additionally, this expansion of patients will increase the patient load on the Medicaid system. Has there been an influx in doctors taking Medicaid? What will this patient surge do to the system?

   Determining an exact figure of people who are Medicaid eligible but not enrolled is difficult. One study suggests that there are 4.5 million uninsured adults who Medicaid eligible but not enrolled (Kenney, et al, 2012) and another study found an estimated 5 million uninsured children are Medicaid or CHIP eligible but not enrolled (Kenney, et al, 2010).

   The priority should be to focus on improving the care for those *currently enrolled* in Medicaid before seeking out eligible-but-not-enrolled individuals and certainly before expanding eligibility to new groups.

   Physician participation in Medicaid has long been a challenge for the program. A recent study found that 1/3 physicians were not accepting new Medicaid patients and it is unclear whether the temporary boost in federal funding for primary care physicians in the ACA will change this trend. The increase in individuals dependent on Medicaid as well as the increase in the number of newly insured individuals as a result of the ACA may likely increase the demand for physician services.

3. How much has this administration embraced experiments in Medicaid? Florida recently got their waiver to roll out a statewide competitive managed care plan, but it took almost two years to obtain the waiver. What has been the experience of other states who applied for waivers, how was it interacting with CMS during the process, and how long did it take for CMS to approve the waiver?

   States have existing authority to experiment, but some experimentation needs federal waiver approval and the process for obtaining a waiver can be laborious. While I am familiar with the

Questions for the Record Responses
Ms. Nina Owcharenko, The Heritage Foundation

Florida waiver and the basic parameters of the waiver process, I have not followed the waiver process for specific states.

4. The recent Oregon Medicaid study published in the New England Journal of Medicine seemed to show that individuals on Medicaid did not have better health outcomes than individuals without health insurance. Have you seen the study and what lessons should we take from it?

The recent Oregon Medicaid study offers new insight into the impact of Medicaid on patients. Heritage analysis by Kevin Dayaratna has also documented the quality of care issue facing Medicaid as does a March 2011 opinion piece in *The Wall Street Journal* by Scott Gottlieb, MD.

5. What reforms are needed to help beneficiaries transition off of Medicaid and into private insurance? What are the challenges that beneficiaries face?

Current beneficiaries face an outdated, one-size-fits-all program that is unable to meet the unique needs of enrollees. To help beneficiaries transition off Medicaid, there should be additional flexibility to adapt Medicaid benefit packages to more closely reflect private insurance, to allow more tailor benefits based on need and ability, and to better integrate private insurance options into Medicaid.

The Honorable Renee Ellmers

1. I am concerned by the high rates of improper payment rates associated with eligibility errors in Medicaid, which over the 2010-2012 period averaged $20 Billion annually according to CMS. Every dollar that is spent in error on someone that could potentially not be a truly eligible Medicaid beneficiary, is a dollar that is taken from our most vulnerable citizens. With Medicaid enrollment at over 70 million now and 1 in 4 Americans expected to become a Medicaid beneficiary as a result of the ACA, do you believe there are measures in place to ensure proper eligibility verification?

While some efforts are being pursued to ensure better eligibility verification, I have some concern with policies to streamline eligibility requirements within Medicaid. Such efforts may potentially save money, but may not be focused on vigorous verification.

2. What impact do you think the delay of the employer mandate reporting requirements might have on the number of individuals improperly enrolled in Medicaid?

The delay of the employer mandate is yet another indication that the Administration is not ready for implementation. The challenges facing this new system go beyond employer reporting requirements which will likely result in people being improperly enrolled, rejected and displaced throughout the whole ACA coverage network.

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July 29, 2013

Mr. Alan Weil
Executive Director
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Washington, D.C. 20036

Dear Mr. Weil:

Thank you for appearing before the Subcommittee on Health on Monday, July 8, 2013, to testify at the hearing entitled "Making Medicaid Work for the Most Vulnerable."

During the hearing, Members asked you to provide additional information for the record, and those requests are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions by the close of business on Monday, August 12, 2013. Your responses should be mailed to Sydne Harwick, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to **Sydne.Harwick@mail.house.gov**.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment

CENTER for HEALTH POLICY DEVELOPMENT
NATIONAL ACADEMY for STATE HEALTH POLICY

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August 12, 2013

Ms. Sydne Harwick
Legislative Clerk
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515

Dear Ms. Harwick:

As a follow-up to the July 8th hearing entitled 'Making Medicaid Work for the Most Vulnerable', please find an attached response to Congressman Michael Burgess's question regarding the Center for Medicare and Medicaid Innovation and the use of multi-payer systems.

Sincerely,

Alan Weil, JD, MPP
President

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Attachment- Response to The Honorable Michael Burgess

The Honorable Michael Burgess

During the hearing, you mentioned the Center for Medicare and Medicaid Innovation and the use of multi-payer systems. Would you provide a reference for that? What was the data that CMMI used to make that determination and how much money was forwarded in those grants?

Information on the Centers for Medicare and Medicaid Innovation State Innovation Models (SIM) initiative can be found at: http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4546&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date

According to information available on the CMMI website, the SIM initiative will provide nearly $300 million to 26 awardee states to "support the development and testing of state-based models for multi-payer payment and health care delivery system transformation with the aim of improving health system performance for residents of participating states." The majority ($250 million) of this funding will be provided to the six 'Model Testing' states (Arkansas, Maine, Massachusetts, Minnesota, Oregon, and Vermont) to implement State Health Care Innovation Plans over a 42-month span.

The SIM awards were made competitively based upon applications submitted by the states.

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Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

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July 29, 2013

Mr. Tarren Bragdon
Chief Executive Officer
Foundation for Government Accountability
15275 Collier Boulevard, Suite 201-279
Naples, FL 34119

Dear Mr. Bragdon:

Thank you for appearing before the Subcommittee on Health on Monday, July 8, 2013, to testify at the hearing entitled "Making Medicaid Work for the Most Vulnerable."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions by the close of business on Monday, August 12, 2013. Your responses should be mailed to Sydne Harwick, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to **Sydne.Harwick@mail.house.gov**.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment

Attachment—Additional Questions for the Record

The Honorable Michael Burgess

1. You have been involved in analyzing Florida's Medicaid Reform pilot over the past five years. A signature component of Florida's Medicaid pilot is the opportunity for Medicaid beneficiaries to have a choice of managed care plans. How has this increased level of choice affected patient health and outcomes? How did this consumer-driven approach to Medicaid affect patient access to providers?

2. Low provider reimbursement rates in many states have led many providers to cease caring for Medicaid patients. How does the program address provider reimbursement rates and maintain provider buy-in to the Medicaid program? How can the federal government ensure provider rates are set at levels that encourage provider buy-in

3. The Florida Medicaid reform plan was predicated on patient choice of health plans. However, recently we've seen plans, like Aetna and United Healthcare, decline to offer coverage in the individual and small group markets in California. How did the Florida Medicaid program ensure there were a sufficient number of plans to offer beneficiaries' choice in plans? How would you ensure an adequate number of plans in rural regions?

4. In a 2011 paper you published for Heritage, you state that if "Florida's Reform Pilot were replicated nationwide…Medicaid programs could save up to $29 billion annually". Do you believe Florida's plan could be replicated and effective in all 50 states? What can other states learn from Florida's Medicaid plan?

The Honorable Gus Bilirakis

1. The current funding formula for Medicaid appears to create an incentive to hurt the most vulnerable of our population. Currently, Medicaid covers traditional populations such as the elderly, the disabled, and children while only paying 57% of the costs on average. But under expanded Medicaid in the ACA, new able-bodied childless adults are eligible with the federal government paying 100% of the bill in the first few years and later 90% of the cost. Does this not create a perverse incentive to target a healthier population rather than the truly needy?

2. Under current law, the system seems to be rigged to maintain the status quo. If a state tries to reform their system to increase outcomes and reduce cost, they typically don't see most of the savings. How can we transform the system to incentivize states and allow them to a greater share of the savings?

3. Some states have attached a work requirement as part of their Medicaid program. Will you elaborate on this requirement, how does it work, and how has it affected the state's Medicaid program?

4. In a recent hearing on Medicare benefit redesign, I asked the panel would it be worthwhile to have the government set an actuarial value and allow for multiple Medicare plans in the marketplace. With Medicaid, at least in Florida, we seem to have taken steps to do that. Consumers may have 31 different benefit packages to choose

among, that may be more options than consumers have in the Health Exchanges. Is it a good idea to provide diversity of plan options to Medicaid beneficiaries?

5. Before Florida created a state-wide managed Medicaid plan, it created a smaller demonstration program. Will you tell us what lessons were learned in the demonstration plan? How does it serve as a model for the state? What were the patient outcomes in the demonstration?

6. The Administration seems focused on expanding Medicaid. How many people are Medicaid eligible and are not enrolled? Shouldn't we be focused on getting care to those groups before we focus on expanding Medicaid? Additionally, this expansion of patients will increase the patient load on the Medicaid system. Has there been an influx in doctors taking Medicaid? What will this patient surge do to the system?

7. How much has this administration embraced experiments in Medicaid? Florida recently received their waiver to roll out a statewide competitive managed care plan, but it took almost two years to obtain the waiver. What has been the experience of other states who applied for waivers, how was it interacting with CMS during the process, and how long did it take for CMS to approve the waiver?

8. The recent Oregon Medicaid study published in the New England Journal of Medicine seemed to show that individuals on Medicaid did not have better health outcomes than individuals without health insurance. Have you seen the study and what lessons should we take from it?

9. What reforms are needed to help beneficiaries transition off of Medicaid and into private insurance? What are the challenges that beneficiaries face?

The Honorable Renee Ellmers

1. I am concerned by the high rates of improper payment rates associated with eligibility errors in Medicaid, which over the 2010-2012 period averaged $20 billion annually according to CMS. Every dollar that is spent in error on someone that could potentially not be a truly eligible Medicaid beneficiary, is a dollar that is taken from our most vulnerable citizens. With Medicaid enrollment at over 70 million now and 1 in 4 Americans expected to become a Medicaid beneficiary as a result of the ACA, do you believe there are measures in place to ensure proper eligibility verification?

2. What impact do you think the delay of the employer mandate reporting requirements might have on the number of individuals improperly enrolled in Medicaid?

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United States House of Representatives

Committee on Energy and Commerce
Subcommittee on Health

Making Medicaid Work for the Most Vulnerable

July 8, 2013

Tarren Bragdon
President and Chief Executive Officer
Foundation for Government Accountability

I am Tarren Bragdon and serve as the President and CEO of the Foundation for Government Accountability. The Foundation is a free-market think tank specializing in health and welfare policy solutions and is based in Naples, Florida. Thank you for the opportunity to testify on this critical issue.

Medicaid currently represents the single largest and fastest growing line item of state budgets.[1] Medicaid spending already represents one-fourth of the federal deficit and federal Medicaid spending is expected to more than double during the next decade.[2] This spending growth is nearly twice as fast as the expected growth in the economy.[3]

But more importantly, Medicaid is failing patients by keeping too many people poor and sick, and robbing them of the hope of a better life. States are currently debating whether or not to expand this broken Old Medicaid program, but that should not be the priority. The priority for states should be to make Medicaid finally work best for patients and taxpayers.

Some states are leading the way. Here are a few strategies that are working well for patients, providers, policymakers and taxpayers:

1. Empowering Medicaid patients with meaningful choices. States such as Florida, Kansas and Louisiana have empowered Medicaid patients to choose the health plans that work best for them. In Florida, for example, patients can choose from up to 13 different health plans offering 31 different and customized benefit packages.[4]

When given meaningful choices and adequate, objective information, Medicaid patients take more control over their health. In Florida's Reform Pilot and in Louisiana's Bayou Health, for example, independent choice counselors assist Medicaid patients in navigating the plan selection process, providing neutral comparisons based on patients' specific needs and concerns.[5-6]

As a result, between 70 percent and 80 percent of patients in Florida's Reform Pilot actively choose their health plan, compared to the 20 percent to 30 percent who let the state automatically

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[1] Brian Sigritz, "State expenditure report: Examining fiscal 2010-2012 state spending," National Association of State Budget Officers (2012), http://www.nasbo.org/sites/default/files/State%20Expenditure%20Report_1.pdf.
[2] Christina Hawley Anthony et al., "The budget and economic outlook: Fiscal year 2013 to 2023," Congressional Budget Office (2013), http://www.cbo.gov/sites/default/files/cbofiles/attachments/43907-BudgetOutlook.pdf.
[3] Ibid.
[4] Florida Agency for Health Care Administration, "Florida Medicaid reform: Year 6 annual report," Florida Agency for Health Care Administration (2012), http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/FL_1115_YR_6_Final_Annual_Report_07-01-11_06-30-12.pdf.
[5] Florida Agency for Health Care Administration, "Florida Medicaid reform: Year 6 annual report," Florida Agency for Health Care Administration (2012), http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/Fl_1115_yr_6_Final_annual_report_07-01-11_06-30-12.pdf.
[6] Medical Vendor Administration, "Request for proposals: Enrollment broker for Louisiana Medicaid coordinated care networks, RFP # 305PUR-DHHRFP," Louisiana Department of Health and Hospitals (2011), http://new.dhh.louisiana.gov/assets/docs/Making_Medicaid_Better/RequestsforProposals/enrollbroker/EB_RFP_FINAL.pdf.

assign them to a plan.[7] In Louisiana, approximately 70 percent of new Medicaid patients actively choose their health plan.[8] Choice counseling programs ensure patients are empowered not only with the ability to choose, but with the knowledge necessary to choose wisely.

This active participation and plan selection illustrates that, when given the power to choose and the information necessary to make an educated decision, patients want to take more responsibility over their health future. In Kansas, for example, American Indians were allowed to opt out of the reforms that offered them a choice of multiple private plans and instead remain in traditional Old Medicaid. But since the reforms launched in January 2013, just 12 American Indians chose to opt out of the reforms and return to Old Medicaid.[9]

The competition among plans has resulted in those plans constantly striving to innovate, improve customer service and maximize the offered benefits and rewards. Costs for these reformed benefit packages have been substantially below spending for similar populations statewide.[10] Florida expects to save nearly $1 billion annually when the reforms are phased in statewide.[11] This example highlights how states are able to deliver more choices to Medicaid patients and still save precious taxpayer dollars.

These customized benefit packages are not only delivering greater choice, they are delivering better results as well. The plans offered in Florida's Reform Pilot outperformed the traditional Old Medicaid program on 22 of 33 widely-tracked health outcomes.[12] Better yet, 94 percent of the Reform Pilot's regularly-tracked health performance measures have improved since 2008.[13] Implementing a robust Medicaid marketplace, where patients choose the health plan that works best for them, has increased access to needed care, improved health outcomes, provided patients with greater satisfaction with the quality of the care and service they receive, and lowered costs for taxpayers.

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[7] Florida Agency for Health Care Administration, "Florida Medicaid reform: Year 6 annual report," Florida Agency for Health Care Administration (2012), http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/Fl_1115_yr_6_Final_annual_report_07-01-11_06-30-12.pdf.

[8] Between January 2013 and May 2013, approximately 56,000 of the 82,000 newly eligible Bayou Health patients made pro-active choices about which health plan in which to enroll. See, e.g., Maximus, "New enrollment by Medicaid eligibility group and health plan," Louisiana Department of Health and Hospitals (2013), http://dhh.louisiana.gov/index.cfm/page/1391.

[9] Division of Health Care Finance, "Quarterly report to CMS regarding operation of 1115 waiver demonstration program: Quarter ending March 31, 2013," Kansas Department of Health and Environment (2013), http://www.kancare.ks.gov/reports/KanCare_Quarterly_Report_QE_3_31_13.pdf.

[10] Tarren Bragdon, "Florida's Medicaid reform shows the way to improve health, increase satisfaction and control costs," Heritage Foundation (2011), http://www.medicaidcure.org/wp-content/uploads/2012/09/Medicaid-Cure-Floridas-Medicaid-Reform-Pilot.pdf.

[11] Ibid.

[12] Florida Agency for Health Care Administration, "Florida Medicaid reform: Year 7, 2nd quarter progress report," Florida Agency for Health Care Administration (2012), http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/Fl_1115_Q2_yr_7_report_10-1-2012_12-31-2012_final.pdf.

[13] Ibid.

2. Integrating work with health outcomes. Kansas has created two unique employment-focused pilot programs that integrate work with health outcomes for individuals with developmental disabilities. The first pilot, which covers individuals receiving SSI who are on the waiting list to receive home and community-based services, provides assistance with obtaining employment and provides up to $1,500 per person per month in employment support services.[14] The second pilot focuses on youth and those who would likely meet the criteria for Social Security Disability but are not yet receiving it. These individuals receive employment assistance focused on jobs with employer-sponsored health coverage and receive wrap-around Medicaid services once enrolled in a work-related health plan.[15]

By integrating employment into Medicaid, KanCare can help these individuals gain opportunities to maintain and improve their skills, helping lead to long-term employment and productivity. Given the strong association between employment and better health, integrating employment services also helps to avoid the culture of poverty, poor health and social isolation stemming from lack of employment.[16]

3. Innovation through private plans. States have also been able to harness, through contracted private plans, innovations which improve quality and reduce costs. By allowing health plans to offer customized and extra benefit packages, states can provide patients with benefits not typically covered by the traditional Old Medicaid program, but which have profound effects on health outcomes. In 2012, plan providers in Florida's Reform Pilot offered 31 different benefit packages, with coverage for over-the-counter drugs, vision, preventive dental coverage, nutrition therapy and respite care included among the value-added extra benefits.[17] In Kansas, individuals can choose plans that offer additional dental benefits, smoking cessation programs, GED programs, Weight Watchers membership and Boys and Girls Clubs membership, among other benefits.[18] Customized and enhanced benefit packages ensure that health plans are able to compete on value by tailoring their benefits to best meet the needs and desires of their patients.

This customization is most evident for patients with very complicated health challenges. In Florida's Reform Pilot, for example, these patients are offered specialty plans tailored to their unique needs. This includes plans developed specifically for medically fragile children and plans customized to best manage HIV/AIDS.[19] Kansas offers programs that are specifically designed

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[14] Division of Health Care Finance, "KanCare: Section 1115 demonstration waiver," Kansas Department of Health and Environment (2013), http://www.kancare.ks.gov/download/KanCare_Section_1115_Demonstration_August_6_2012.pdf.
[15] Ibid.
[16] Ellie C. Hartman, "A literature review on the relationship between employment and health: How this relationship may influence managed long term care," Wisconsin Department of Health Services (2008), http://www.dhs.wisconsin.gov/wipathways/ResearchDocs/litrevw.pdf.
[17] Florida Agency for Health Care Administration, "Florida Medicaid reform: Year 6 annual report," Florida Agency for Health Care Administration (2012), http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/Fl_1115_yr_6_Final_Annual_Report_07-01-11_06-30-12.pdf.
[18] Division of Health Care Finance, "Medicaid for Kansas: Choosing a KanCare health plan," Kansas Department of Health and Environment (2013), http://www.kancare.ks.gov/choosing_a_plan.htm.
[19] Ibid.

to help manage complicated conditions such as HIV/AIDS and schizophrenia.[20] Specialty plans ensure that patients with complicated health challenges can receive the unique care they deserve.

Private plan innovation is not just occurring in plan customization. Private plans are also innovating wellness programs. These wellness programs adopt incentive structures that reward Medicaid patients for healthy behavior. Patients in Florida's Reform Pilot plans can earn up to $125 per year for receiving certain preventive services, complying with maintenance and disease management programs, keeping appointments and engaging in other healthy behaviors.[21] Individuals may then use these rewards to purchase over-the-counter items at participating pharmacies.[22] In Kansas, patients can choose plans that offer cash incentives for healthy behaviors, such as getting vaccinations, regular checkups and the like.[23]

This kind of wellness program further encourages Medicaid patients to take control of their own health by offering financial incentives for engaging in healthy behaviors. Similar wellness rewards programs operate through contracted Medicaid managed care organizations in Arizona, Georgia, Illinois, Indiana, Kentucky, Louisiana, Massachusetts, Missouri, Mississippi, New Hampshire, Ohio, South Carolina, Texas, Washington and Wisconsin.

In Ohio, for example, patients can earn up to $175 for preventive services and disease management. Pregnant mothers may earn up to $100 for completing regular prenatal visits and parents can earn another $100 for completing regular well-child visits. In South Carolina, parents can earn an extra $105 just for completing regular well-child visits.

But not all programs are innovating. Here are a few things that are not working:

1. Perverse funding formulas. Under the Patient Protection and Affordable Care Act, states that choose to expand Medicaid coverage will receive an enhanced matching rate for the new Medicaid population.[24] This population consists primarily of able-bodied adults without children and low-income parents.[25] The enhanced matching rate for the newly eligible population starts at 100 percent in 2014 and then gradually reduces to 90 percent by 2020.[26]

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[20] Division of Health Care Finance, "KanCare: More choices, better access, healthy patients," Kansas Department of Health and Environment (2013), http://www.kancare.ks.gov/download/KanCare_ProPatient_ProTaxpayer.pdf.

[21] Florida Agency for Health Care Administration, "Florida Medicaid reform: Year 6 annual report," Florida Agency for Health Care Administration (2012), http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/Fl_1115_yr_6_Final_annual_report_07-01-11_06-30-12.pdf.

[22] Ibid.

[23] Division of Health Care Finance, "Medicaid for Kansas: Choosing a KanCare health plan," Kansas Department of Health and Environment (2013), http://www.kancare.ks.gov/choosing_a_plan.htm.

[24] 42 U.S.C. § 1396d(y).

[25] Genevieve M. Kenney et al., "Opting into the Medicaid expansion under the ACA: Who are the uninsured adults who could gain health insurance coverage?" Urban Institute (2012), http://www.urban.org/UploadedPDF/412630-opting-in-medicaid.pdf.

[26] 42 U.S.C. § 1396d(y).

The matching rate for currently eligible individuals, on the other hand, ranges from 50 percent to 83 percent, with the federal government typically paying an average of 57 percent of Medicaid expenditures.[27] This means that states will receive less federal support to provide services to the most vulnerable; those patients currently eligible for Medicaid, including the elderly, individuals with disabilities and children. This perverse funding formula provides states with incentives to cut services and benefits for the most vulnerable, giving preferential treatment to adults without any disabilities or dependent children.

There are more than 511,000 individuals on waiting lists to receive home and community-based services through Medicaid.[28] Those on waiting lists include individuals with intellectual disabilities, developmental disabilities, traumatic brain and spinal cord injuries, physical disabilities, mental health conditions and HIV/AIDS.[29] The Medicaid expansion's perverse funding formula ensures these individuals will be kicked to the end of the line in order to provide coverage to able-bodied adults in the states that opt to expand.

2. A too expansive, broken program. When broken Old Medicaid programs become too expansive, states often delay payments to doctors, hospitals and other providers in order to make ends meet. For example, Illinois owed doctors, hospitals and other medical providers more than $2 billion for unpaid Medicaid services at the end of fiscal year 2012.[30] The average medical provider waited more than 5 months to receive reimbursement for their services, with some delays lasting eight months or more.[31-32] These reimbursement delays occurred despite federal law requiring states to pay 90 percent of Medicaid bills within 30 days and 99 percent within 90 days.[33]

Earlier this year in Maine, a coalition of 39 hospitals demanded $484 million for unpaid Medicaid bills dating back to 2009.[34] The hospitals went so far as to launch radio and newspaper advertisements to build public pressure on state policymakers to pay down the backlog of Medicaid bills. Of course, Maine expanded Medicaid eligibility to able-bodied adults without

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[27] 42 U.S.C. § 1396d(b).
[28] Kaiser Commission on Medicaid and the Uninsured, "Waiting lists for Medicaid section 1915(c) home and community-based service (HCBS) waivers," Kaiser Family Foundation (2013), http://kff.org/medicaid/state-indicator/waiting-lists-for-hcbs-waivers-2010/.
[29] Ibid.
[30] John Sinsheimer, "General obligation bonds, Series A and B of April 2013," Illinois Governor's Office of Management and Budget (2013), http://www.state.il.us/budget/ILState02a-FIN.pdf.
[31] Mallory Meyer et al., "State of Illinois budget summary: Fiscal year 2012," Illinois Commission on Government Forecasting and Accountability (2011), http://cgfa.ilga.gov/Upload/FY2012BudgetSummary.pdf.
[32] Jennifer Levitz and Louise Radnofsky, "Delays in Medicaid pay vex hospitals," The Wall St. Journal (2013), http://online.wsj.com/article/SB10001424127887324442304578234020690323296.html.
[33] 42 C.F.R. § 447.45(d)
[34] Jennifer Levitz and Louise Radnofsky, "Delays in Medicaid pay vex hospitals," The Wall St. Journal (2013), http://online.wsj.com/article/SB10001424127887324442304578234020690323296.html.

children in 2002.[35] Its Medicaid expansion far exceeded projected costs, forcing the state to cap enrollment in the program at various times and lengthen payment cycles to cope.[36]

Likewise, Arizona expanded Medicaid eligibility to childless adults in 2000.[37] But the expansion cost four times what was expected, forcing policymakers there to cut other areas in order to maintain the expansion.[38] Indeed, Arizona had to eliminate Medicaid coverage for heart, liver, lung, pancreas and bone marrow transplants in 2010 in order to pay for the growing costs of its Medicaid expansion.[39]

These payment delays and service cuts – emblematic of an expansive, broken program – ensure that Medicaid patients will face greater difficulty in finding doctors willing to treat them, likely resulting in worse health outcomes.

3. Slow, inflexible federal waiver processes. For many states, the waiver process is a long, drawn-out and complex negotiation with CMS. States face burdensome reporting requirements, subjective deadlines and general uncertainty about whether and when CMS will approve requested reforms. Even if a state receives a federal waiver to implement its desired reforms, the waiver lasts just three to five years.[40] After that time, it must either seek an optional extension of the waiver or submit a new waiver request altogether if it wants to continue its reforms. Even reform ideas that have proven effective elsewhere must follow this slow, inflexible process and states have no guarantee that the federal government will grant them permission to implement these effective reforms.

4. New taxes on private plans. The Affordable Care Act imposes a new $8 billion tax on private health plans, starting in 2014. This tax gradually increases to more than $14 billion in 2018, then increases at the annual growth in premiums. Strangely, this new tax also applies to Medicaid plans in states that have reformed their programs with managed care. Because the Medicaid managed care rates are required by federal law to be actuarially sound, the cost of this new tax will be borne by state and federal taxpayers. This results in a situation where the federal government is taxing both itself and states, increasing Medicaid costs and shifting more costs to the states.

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[35] Alexis Gibson, "MaineCare for childless adults: Section 1115 demonstration," Centers for Medicare and Medicaid Services (2011), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/me/me-childless-adults-fs.pdf

[36] Jonathan Ingram, "Medicaid expansion: We already know how the story ends," Foundation for Government Accountability (2013), http://www.medicaidcure.org/wp-content/uploads/2013/03/Medicaid-Expansion-We-Already-Know-How-the-Story-Ends-Medicaid-Cure-Policy-Brief-31.pdf.

[37] Jennifer Vermeer, "Ballot proposition 204, Healthy Arizona: Publicity pamphlet fiscal impact summary, revised Aug. 17, 2000," Arizona Joint Legislative Budget Committee (2000), http://www.azleg.gov/jlbc/ballotprop204.pdf.

[38] Jonathan Ingram, "Medicaid expansion: We already know how the story ends," Foundation for Government Accountability (2013), http://www.medicaidcure.org/wp-content/uploads/2013/03/Medicaid-Expansion-We-Already-Know-How-the-Story-Ends-Medicaid-Cure-Policy-Brief-31.pdf.

[39] Kevin Sack, "Arizona Medicaid cuts seen as sign of the times," New York Times (2010), http://www.nytimes.com/2010/12/05/us/05transplant.html.

[40] Section 1115 waivers are generally approved for five-year periods, Section 1915(b) waivers are generally approved for five-year periods and Section 1915(c) waivers are generally approved for three-year periods.

Nearly one-fifth of this new tax on private plans is expected to be borne by Medicaid programs.[41] The tax is expected to increase Medicaid capitated rates by up to 2.5 percent for some states, with the national average falling somewhere between 1.5 percent and 1.6 percent.[42] This amounts to between approximately $37 billion and $42 billion in increased Medicaid costs during the next ten years, with much of that added burden falling on state governments.[43] Adding a new tax on Medicaid plans will only accelerate the mayhem Medicaid programs are already creating for state budgets.

States are leading the way, implementing innovative solutions to the persistent problems Old Medicaid has created. But federal rules and regulations often hinder state leaders who want to make their Medicaid safety nets more responsive to patients, more accountable to policymakers and more affordable to taxpayers. Additional flexibility from the federal government should give each individual state the opportunity to build a Medicaid safety net to best serve patients and taxpayers.

A few recommendations to provide states with additional flexibility include:

1. Reject the one-size-fits-all expansion. Expanding Medicaid eligibility diverts scarce Medicaid resources away from the truly vulnerable in order to fund coverage for able-bodied adults. Prioritizing able-bodied adults above the elderly, individuals with disabilities and low-income children will only exacerbate the many problems present in Old Medicaid.

The various fiscal and health promises made by expansion supporters have already been broken in the states that have previously expanded eligibility to this group of people. They are likely to be broken in the states that opt into the Affordable Care Act's Medicaid expansion.[44] Medicaid expansion, including its perverse funding formula, should be rejected and states should regain their control over eligibility levels based on the needs, culture and values of their own state population.

2. Remove perverse funding dynamics. Under current law, states that implement innovative reforms see the majority of their savings go to the federal government, not to the states themselves. Under current Medicaid matching rates, states can expect to see only 17 percent to 50 percent of the savings their innovative reforms achieved. This creates a disincentive for states to make meaningful changes, as the lion's share of savings will accrue to the federal government.

The federal government could reduce this perverse funding dynamic by granting states flexibility and incentives to better share those savings. Doing so would promote innovation and provide

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[41] John D. Meerschaert et al., "PPACA health insurer fee estimated impact on state Medicaid programs and Medicaid health plans," Milliman (2012), http://publications.milliman.com/publications/health-published/pdfs/ppaca-health-insurer-fee.pdf.
[42] Ibid.
[43] Ibid.
[44] Jonathan Ingram, "Medicaid expansion: We already know how the story ends," Foundation for Government Accountability (2013), http://www.medicaidcure.org/wp-content/uploads/2013/03/Medicaid-Expansion-We-Already-Know-How-the-Story-Ends-Medicaid-Cure-Policy-Brief-31.pdf.

states with a greater financial incentive to implement bold solutions. Although this recommendation would appear to increase federal spending, in practice it would reduce federal spending as states would have strong incentives to innovate and generate savings with Medicaid reform, something lacking today.

3. Allow proven waivers to be seamlessly incorporated into state plan amendments. The waiver process is often accompanied by uncertainty about whether and when the federal government will approve requested reforms. Because waivers have a limited duration, this uncertainty persists even for reforms that have proven effective and popular. Currently, states are operating under 378 different active waivers and have another 27 waivers pending with the Centers for Medicare and Medicaid Services.[45]

Congress could embrace an accountable, common sense approach to Medicaid oversight by granting states the flexibility to turn previously-approved waivers into permanent state plan amendments once the waivers have been proven effective. Doing so alleviates the stress and uncertainty states now face as their waivers approach scheduled expiration dates. This also ensures patients' care and taxpayer savings do not face interruptions resulting from lengthy renegotiations with CMS. Further, states should be able to incorporate a reform proven effective in other states into their own state plans without enduring the burdensome waiver process and scrutiny the reform already received elsewhere.

This would allow states to avoid months- or years-long delays for waiver approval. Reforms accomplished through state plan amendments can expect approval within 180 days. And rather than needing approval again after just a few years, a state plan amendment becomes a permanent part of a state's Medicaid program unless changed by a future state plan amendment.

4. Provide greater flexibility on mandatory and optional services. Customized benefit packages provide patients with the greatest value and competition among plans has proven effective at reducing costs for taxpayers. In Florida, Medicaid patients can choose from up to 31 different, customized benefit packages.[46] The state allows health plan providers to offer customized benefit packages as long as the benefit packages are actuarially equivalent to the state plan and still provide key benefits at a level sufficient to meet patient needs.[47]

But states and health plan providers are hamstrung by federal rules dictating how much they can customize benefits. Federal rules require coverage for inpatient hospital services, outpatient hospital services, early and periodic screening, diagnostic and treatment services, nursing facility

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[45] Centers for Medicare and Medicaid Services, "Medicaid waivers: Dynamic list," U.S. Department of Health and Human Services (2013), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/dynamic-list/WA-508.xml.

[46] Florida Agency for Health Care Administration, "Florida Medicaid reform: Year 6 annual report," Florida Agency for Health Care Administration (2012), http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/FL_1115_YR_6_Final_Annual_Report_07-01-11_06-30-12.pdf.

[47] Florida Agency for Health Care Administration, "Florida Medicaid reform: Application for 1115 research and demonstration waiver," Florida Agency for Health Care Administration (2005), http://ahca.myflorida.com/medicaid/medicaid_reform/waiver/pdfs/medicaid_reform_waiver_final_101905.pdf.

services, home health services, laboratory and x-ray services, family planning services, nurse midwife services, certified pediatric and family nurse practitioner services, freestanding birth center services, transportation to medical care and tobacco cessation services.[48] States may only choose which additional services to offer and set the scope and range of those services.

With added flexibility from the federal government, states could offer more customized benefit packages to vary these minimum benefits, so long as the benefit packages meet specified actuarial standards. One potential avenue for this customization would be to grant states much more flexibility for benchmark Medicaid coverage.

States currently have the option to design benefit packages for certain populations that vary from traditional Old Medicaid.[49] However, the flexibility provided in designing these benefit packages, known as "benchmark coverage" or "benchmark-equivalent coverage," is limited in nature. The benefit packages must be equivalent to the standard Blue Cross/Blue Shield health plan offered to federal employees, the health plan offered to state employees or the largest commercial, non-Medicaid health maintenance organization plan offered in the state.[50] Benchmark-equivalent coverage must also provide specified mandatory services.[51] Current law also requires states to "wrap around" benchmark coverage with additional benefits not typically covered by private insurance, such as transportation services to and from medical visits.[52] The Affordable Care Act further requires such benchmark-equivalent coverage include all essential health benefits.

Given adequate flexibility, states could restructure their covered benefits to provide truly patient-centered customized benefit packages. And if plans meet a target actuarial value, states should be free to allow plans to be offered that vary covered services and benefits, including those that are federally mandated, as well as the amount, duration and scope of those services. States would evaluate each proposed customized benefit plan in order to ensure plans meet the target actuarial value.

This will create greater competition within the Medicaid marketplace, lowering the cost to taxpayers and improving quality. Patients will be able to prioritize benefits according to their personal needs and circumstances and select the plans that will provide them with the greatest value. For example, a patient may wish to select a plan that does not offer transportation services, but instead select a plan that offers a better dental benefit package. They deserve that choice.

5. Create an off-ramp for Medicaid. Currently, federal restrictions on marketing private insurance plans to individuals transitioning off of Medicaid impose an undue burden on those leaving Medicaid. These restrictions further worsen the gaps in coverage for individuals leaving

[48] Centers for Medicare and Medicaid Services, "Medicaid benefits," U.S. Department of Health and Human Services (2013), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html.
[49] 42 C.F.R. § 440.300 et seq.
[50] 42 C.F.R. § 440.330.
[51] 42 C.F.R. § 440.335.
[52] 42 C.F.R. § 440.390.

Medicaid. As Florida's Reform Pilot has proven, Medicaid patients can and do make informed choices about their health coverage when given access to appropriate information. Denying them such information while they are transitioning off of Medicaid hinders their ability to make educated choices, taking away their power to make meaningful decisions over their health futures.

Other federal rules and regulations restrict states from using Medicaid funding in innovative ways to move individuals off of Medicaid and into private coverage. With greater flexibility in this area, states would be able to take proactive steps to create an off-ramp for Medicaid, helping ensure that Medicaid patients are not trapped in government dependency and a culture of poverty, but rather help them move from poverty into long-term employment and productivity.

Conclusion

Despite Medicaid's fiscal challenges to state budgets and the federal budget, there are proven strategies that are working today for both Medicaid patients and taxpayers. However, the current funding structure, new taxes, a slow federal process, and perverse incentives inherent in Medicaid expansion threaten Medicaid services to the most vulnerable. It doesn't have to be that way. With reasonable flexibility, targeted incentives, streamlined administration, and a smooth off-ramp, the Medicaid safety net can work better today for patients and providers and be sustainable for taxpayers into the future.